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AN INDEPENDENT LIVING REHABILITATION PROGRAM FOR SERIOUSLY HANDICAPPED MENTALLY RETARDED ADULTS. FINAL REPORT.

San Francisco Aid Retarded Children, Calif.

Spons Agency-Vocational Rehabilitation Administration (DHEW), Washington, D.C.

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Descriptors-*ADJUSTMENT (TO ENVIRONMENT), COMMUNITY PROGRAMS, EDUCABLE MENTALLY HANDICAPPED, *EXCEPTIONAL CHILD RESEARCH, INTERPERSONAL COMPETENCE, *MENTALLY HANDICAPPED, PROGRAM EVALUATION, *PROGRAM PLANNING, TRAINABLE MENTALLY HANDICAPPED, *VOCATIONAL REHABILITATION, VOCATIONAL TRAINING CENTERS, YOUNG ADULTS

The Independent Living Rehabilitation Program provided non-residential community rehabilitation to meet the personal, vocational, and social needs of seriously mentally handicapped young adults. After both an initial and an 8-week evaluation period, 75 enrollees were admitted for up to 2 years of training. Of the 75, 57% were classified as educable, 40% as trainable, and the remainder as mild (IQ over 75). Half were under 20 years of age. Of the 56 enrollees who completed the program's work-training experiences and social services, 13 were vocationally rehabilitated and 23 were placed in the Adult Training Center with only limited provision for gainful employment. Although there was no change in social competency ratings, some improvements were noted in a greater independence, the use of social services, and global ratings. Information on the program is given concerning influences, admission, referral sources, enrollees, and effect. Areas of program organization detailed are direct and supportive services, training and social services, the community, staffing and administrative tasks, and program evaluation procedures. Also provided are a 53-item bibliography, 27 tables (on the enrollees' characteristics, backgrounds, and progress ratings), three case studies, and a social competency rating scale. (BW)

INDEPENDENT LIVING REHABILITATION PROGRAM

FOR SERIOUSLY HANDICAPPED MENTALLY RETARDED ADULTS

902

PROJECT NO. RD-905
DEC. 1961-OCT. 1965

ELIAS KATZ PH.D.
PROJECT DIRECTOR

SAN FRANCISCO AID RETARDED CHILDREN
MRS. MARGARETE CONNOLLY EXEC. DIR.

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SAN FRANCISCO AID RETARDED CHILDREN

1362 9th Avenue
San Francisco
LO 6-3022

December 30, 1965

Miss Mary E. Switzer, Commissioner
U.S. Vocational Rehabilitation Administration
Department of Health, Education and Welfare
Washington, 25, D.C.

Dear Miss Switzer:

It is our honor to forward to you herewith the final report of the four-year Research and Demonstration Project on Independent Living Rehabilitation Program (Vocational Preparation) conducted by San Francisco Aid Retarded Children in concert with the Vocational Rehabilitation Administration.

As you are aware, this project grew out of lack of success in work-training with certain clients, and out of recommendations in the literature. The two primary targets were major involvement of family members in the goals of the person with mental retardation and an attack on the emotional factors which frequently impede progress.

We are confident that we have demonstrated that consideration of these two factors are crucial to success in the vocational evaluation and training of certain seriously handicapped mentally retarded adults. We have not succeeded to the extent we had hoped in carrying the message of this project to the rehabilitation community.

It may be that the factors impeding full employment of moderately retarded adults are still so great that the concerned community is not yet ready to focus on those with more serious problems.

Of this fact we are convinced: preparing young men and women to live independently or semi-independently in the community while making a contribution to that community has the potential of saving millions of dollars annually in residential institution costs.

At this writing, it is our intention to continue the program with workshop fees being paid by the State Department of Rehabilitation and local community resources funding the balance. It is our intention to continue working with the state agency to find a sound base of support.

MEMBER OF:

California Council for
Retarded Children

National Association for
Retarded Children

Member Agency
United Community Fund
(San Francisco's
United Crusade)

RETARDED CHILDREN
CAN BE HELPED

All contributions Tax Exempt

We have been pleased at the opportunity given us to use Federal funds to develop programs which reflect local convictions and local needs. Matching funds contributed by the Bothin Helping Fund, Fleischman Foundation, the San Francisco Foundation and other trusts and foundations have made this project possible, ans we wish to acknowledge publicly this support.

Working with your staff members and with staff members of the California Department of Rehabilitation has been a rewarding experience.

Thank you for your many kindnesses.

Cordially yours,

Wm. Hunt Conrad
President

WHC/MC:pw

cc: Warren Thompson
Andrew Marrin

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

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AN INDEPENDENT LIVING REHABILITATION PROGRAM FOR SERIOUSLY HANDICAPPED MENTALLY RETARDED ADULTS

Project Director: Elias Katz, Ph.D.

San Francisco Aid Retarded Children, Inc.

San Francisco, California

Mrs. Margarete Connolly, Executive Director

November 1965

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Many volunteers gave their time and effort: Judith Barry, Olive Backus, Burton Dagitz, Jr., Janet Diest, Robert Dorey, Helen Emery, Larry Higa, Susanna Hwa, George Irizary, Maxine Kaufman, Joyce Kramer, Joseph Latham, Melvin Lew, Violet Reichle, Alexandra Robbins, Judy Romanoff, David Sampson, Zurna Schlotzhauer, Melinda Williams, and Gloria Woo.

Recognition should be made of colleagues in other agencies, and the many friends who shared their thoughts with me and other staff members. Credit must be given to the Vocational Rehabilitation Administration, which provided essential financial support and to the State Department of Rehabilitation which was involved at each step of the project. The specific contributions of the Adult Education Division of the San Francisco Unified Schools, and the Community Mental Health Services of the San Francisco Health Department are acknowledged in the body of the report.

I am indebted to the Board of Directors and the membership of San Francisco Aid Retarded Children, who sponsored the project, and to Mrs. Margarete Connolly, Executive Director, for her counsel. My wife, Florence, has been an inspiration and has assisted me in preparing this report.

I dedicate this report to mentally retarded adults everywhere, in the hope that these ideas may help them and those responsible for their welfare to fulfill their potentials as citizens.

Elias Katz, Ph.D.

November, 1965
EK:pw

CHAPTER 1

INTRODUCTION

During the past few years it has become increasingly clear that there are gaps in providing vocational rehabilitation services to the mentally retarded (m.r.)* adult. These gaps are most noticeable in services to seriously handicapped m.r. adults with a limited vocational potential, or with blocks to achieving their potentials. Little has been done to evaluate their potentials, to train and to counsel them, to work with their parents, and to move them on to programs where they can use their capabilities most effectively.

The purpose of this Final Report is to describe in some detail the "Independent Living Rehabilitation Program" (ILRP), a project conducted by San Francisco Aid Retarded Children, Inc., (SFARC), with financial support from the Vocational Rehabilitation Administration (VRA), U.S. Department of Health, Education and Welfare, and other sources (primarily from the San Francisco Public Schools and private foundations) from December 1, 1961 to November 1, 1965. The report presents the project goals, the background, methodology, results obtained, conclusions and recommendations.

The ILRP is based on the concept that retarded adults have complex needs which can best be met by providing a comprehensive, integrated, and flexible program adjusted to the individual enrollee and his family. To the writer's knowledge, there is no existing model on which to base the ILRP, so that the program includes original as well as traditional aspects. Like other sheltered workshops, there is a heavy emphasis on productive work in a work setting as a means of developing good work habits and attitudes which the enrollee can use in obtaining and holding a job. The ILRP goes far beyond a concept that the rehabilitation effort should be limited to helping the person to get and hold a job, even if this is to be in a sheltered setting. Among the unique aspects of the ILRP is the variety of daily training and counseling experiences which are intended to help the enrollee not only to be a better worker, but be better able to adjust to community living, fit into his family setting, and take care of his recreation and social needs. In some m.r. persons, failure in these latter areas of living constitutes a far more serious disability than their lack of productive work abilities.

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* "Mental retardation","mentally retarded" will be abbreviated as "m.r."

General Project Goal

The general objective of the ILRP is to develop and demonstrate a non-residential community rehabilitation program which would meet the personal, vocational and social needs of seriously handicapped mentally retarded young adults so that they might achieve higher levels of self-care, self-support and independence in daily living. This goal is to be achieved by evaluating the present strengths and potentials of the clients and providing appropriate training, social services, parent counseling, vocational counseling and socialization experiences.

Categorically this project is classified as a "demonstration" project; however, it is conceived as a service program which is an integral part of a broad community action program on behalf of the retarded and other handicapped persons, which has been taking shape during the past few years in San Francisco.

Specific Goals

The specific objectives of the ILRP may be stated as follows:

1. To develop and to demonstrate a non-residential community rehabilitation program which would meet the needs of seriously handicapped m.r. young adults:

a. by providing a comprehensive evaluation of personal, social and vocational potential over an extended time period, up to a maximum of two years;

b. by training them in skills of independent living, with a view to achieving self-care and some measure of self-support;

c. by using social services to help the enrollees explore the norms and values of the community and to motivate them to strive toward greater independence within this framework; and to help their parents or guardians integrate the enrollee's achievements into the home;

d. by providing a transition from school to community living for those m.r. youth who could profit from the ILRP after "graduating" from San Francisco Public School classes for the retarded at 18 years;

e. by providing a transition from institutional to community living for patients of the State Department of Mental Hygiene who had been released to the San Francisco Community from state hospitals for the retarded;

f. by providing a community program which would give an alternate choice to commitment to a state hospital for the retarded for certain m.r. adults;

2. To document and evaluate improvement in independent living skills among enrollees as a result of ILRP services.

3. To cooperate with the State Department of Rehabilitation in making and receiving appropriate referrals to and from that agency, as well as in total planning for enrollee rehabilitation services.

4. To strengthen and enrich opportunities for professional training in mental retardation in social work, rehabilitation counseling, special education, medicine, psychology and related disciplines through provision of field work and opportunities for intensive observation.

5. To determine the role of the ILRP in a total community organization plan for improved services to the mentally retarded adult in San Francisco, including relationships between the ILRP and the San Francisco Community Rehabilitation Workshop, and agencies representing other disability groups for whom this program would be appropriate.

6. To develop a long-term financial support basis so that the services provided can be continued after the federal grant support has ended.

7. To develop and make available procedures and techniques applicable to other communities in the Western Region of the U.S. faced with the same problems.

CHAPTER 2

BACKGROUND OF THE PROJECT

In order to give some feeling of the influences which shaped the ILRP, reference will be made to some national, state and local developments which had direct and indirect effects on the project.

National Influences on Project

The title "Independent Living Rehabilitation Program" is directly derived from national legislative proposals embodied in H.R. 3756, "the Rehabilitation Act of 1961", introduced in the 87th Congress, First Session, February 2, 1961. Although the bill was not passed as originally presented, the following extracts will give some indication of the influence the bill had on the design of the ILRP. H.R. 3756's stated goal was:

". . .To encourage needed evaluation of rehabilitation potentials of, and the provision of rehabilitation services to handicapped individuals who may engage in gainful work or achieve substantial ability of independent living, thereby eliminating or reducing their burden on others and contributing to their dignity and self-respect; to assist in the establishment of public and private nonprofit evaluation and rehabilitation facilities; and for other purposes.

". . .The Congress hereby finds and declares -

(1) that many severely handicapped persons, including the mentally ill or retarded, and older persons, not feasible for vocational rehabilitation, as a result of independent living rehabilitation services can achieve such a degree of independence that -

(a) their institutional care can be terminated, or

(b) their need for an attendant's care at home will be ended, or substantially reduced, and

(c) in many instances these individuals will be found to be capable of vocational rehabilitation and will become gainfully employed taxpayers;

(2) That the provision of independent living rehabilitation services to such severely handicapped persons ends or minimizes the public and family burden of providing them with attendant's care, contributes greatly to their dignity and self-respect, and is in the public interest;

(3) that effective evaluation of rehabilitation potentials of disabled individuals is essential to effective and economical provision of independent living and vocational rehabilitation services, under State programs and should be encouraged;

(4) that there is a grave shortage of rehabilitation facilities where evaluation, independent living and vocational rehabilitation services are provided the severely handicapped, including hearing and speech correction, fitting and use of prosthetic devices, personal adjustment, prevocational and vocational training, and particularly of centers providing a variety of such services;

(5) that there is a grave shortage of rehabilitation facilities, particularly sheltered workshops, wherein work capacities of severely handicapped can be evaluated and developed, and can also be utilized in productive work in cases where the handicapped individual is not absorbable in the competitive labor market; and

(6) greatly expanded development and utilization of evaluation services and facilities, particularly integrated units, are required and in the public interest; and

(7) that Federal grants assisting in the provision of the foregoing rehabilitation facilities and services are required in the public interest as a necessary expansion of present grants under the Vocational Rehabilitation Act."[1]

Many organizations and individuals supported H.R. 3756. The major spokesman for its support was the National Rehabilitation Association (NRA). In testimony before Congressional Committees studying this legislation, the following statements were made by Mr. E. B. Whitten, Executive Director of NRA:

"NRA's proposals were inspired mainly by the following facts. All studies of disabled persons in this country have indicated that there is a tremendous number of severely handicapped individuals who do not meet the generally accepted standards for the provision of Vocational Rehabilitation Services (by appropriate State agencies). Many of these people have been identified by applications made to Vocational Rehabilitation Divisions in the states. The process of determining eligibility of applicants for disability and "freeze" benefits under Social Security has revealed the presence of additional thousands of individuals whose disabilities are so great that extensive evaluation services will be necessary before rehabilitation potential can be determined....In further studying this problem, it becomes apparent that many such severely disabled persons, if provided with proper evaluation and restorative services, would be found to possess varying degrees of vocational potential. Others might have to accept objectives that do not include vocational achievement.

"NRA is convinced that there are hundreds of thousands of individuals in this latter category who are at the present time relegated to the human waste heap. NRA feels strongly that such individuals should have the opportunity to make the most of their potentials, without regards to what their ultimate accomplishments may be....

"It became necessary to select a name to identify rehabilitation services for individuals whose objectives might be other than vocational. The term "independent living" rehabilitation services was chosen as being the most descriptive of the services contemplated.

"NRA feels that the addition of 'Independent Living' rehabilitation services to those provided by the state rehabilitation agencies will result in a tremendous improvement in vocational rehabilitation services. This will be particularly true of those severely handicapped individuals who are expected to progress through Independent Living Rehabilitation services to vocational rehabilitation services."[2]

While no specific use of the term "Independent Living Rehabilitation Services" is included in the Vocational Rehabilitation Act Amendments of 1965 (PL 89-333) similar provisions are incorporated in that legislation.[3]

From still another viewpoint, the American Association on Mental Deficiency (AAMD), and the National Association for Retarded Children (NARC) in its publications, have stressed the need for providing services for the more severely retarded adults, as an integral part of a total coordinated program for the mentally retarded.

The following from the AAMD Monograph is pertinent:

"5. Training and Sheltered Workshops.

"There are many educable mentally retarded who may not be ready for placement in competitive employment at the time they complete their special education in the public schools and need additional experience in a training workshop. When severely retarded children complete their special class programs for trainable children, they need opportunities to learn and work and achieve partial self-support in a sheltered environment. Otherwise they must remain unoccupied at home.

"A considerable number of training and sheltered workshops are being operated throughout the country. Most of them are supported by private funds although a few have received temporary grants from the Federal Office of Vocational Rehabilitation (now Vocational Rehabilitation Administration). They are still in the experimental stages of development although they should be regarded as an essential part of a comprehensive program for the mentally retarded..

"6. Other Adult Needs.

"The adult needs of the mentally retarded who live in communities will depend on their levels of functioning. A large proportion of the educable group will have jobs and be self-supporting, marry and rear families, and participate in the existing social, recreational, civic and religious activities of their communities. They could profit from adult education programs adapted to their specific needs because of limitations in academic learning. Counseling services should be available to them at times when critical decisions in their lives have to be made.

"The situation for those with more severe retardation or the trainable group is quite different. Programs of sheltered employment, social and leisure time activities should be provided especially designed to meet their specific needs."[4]

The following quotation from the NARC publication by Willian Fraenkel is also pertinent:

"As we look into the not too distant future there may very well be the need to think more in terms of vocational rehabilitation services to be extended further (through legislation) to some retardates, who at the outset, appear not to be suitable candidates for vocational rehabilitation but who can with special rehabilitation services be enabled to live a less dependent life both at home and in the community."[5]

The President's Panel on Mental Retardation during 1960-1962 contributed heavily to the concept that programs to combat mental retardation should provide for seriously handicapped mentally retarded adults. Among its ideas were:

"The limitations of many retarded persons prevent them from working in any place other than a sheltered environment. Traditionally, this sheltered environment has been a sheltered workshop....."

"Currently Federal grants for vocational rehabilitation services are available only for services granted to indivudlals for whom there is a reasonably clear 'potential for employment'. In some cases the 'potential' may be absent at the beginning, but may become reasonably clear after rehabilitation services have begun to work their change...."[6]

State Influences on Project

On the State level, several developments influenced the ILRP.

From the start, the State Department of Rehabilitation welcomed the plans to establish the ILRP as a VRA project. This support was reinforced by tangible actions such as providing consultation services through the Department's Rehabilitation Workshop Consultant, through close cooperation of their San Francisco Office Rehabilitation Counseling Staff in referral of clients to and from the ILRP, and through financial support by fees for clients referred by the Aid to the Disabled (ATD) Program of the San Francisco City and County Department of Social Services (formerly Department of Public Welfare) in 1964 and 1965.

As an outgrowth of the President's Panel on Mental Retardation, the California State Study Commission on Mental Retardation was established by the Legislature in 1963, to draw up proposals for the development of services. The resulting Report and Recommendations[7] amply supported proposals for the development and expansion of services for seriously handicapped m.r. adults, such as are being provided in the ILRP.

Another state-wide development was the California Council for Retarded Children (CCRC), the State organization of parents and friends of the retarded, which developed an increasing interest in the retarded adult through its Vocational Habilitation Committee* and programs of services by local units. Through CCRC it has been possible to contact other communities in California concerned with the growth of services for the more severely handicapped m.r. adult.

The rapid rise in the number of sheltered workshops in California, especially those serving m.r. adults (of a total of 140 workshops in California, more than 40 are concerned almost exclusively with the m.r.), was reflected in the growth of the California Association of Rehabilitation Workshops (CARW), formerly California Conference of Workshops for the Handicapped. Through participation in this organization it has been possible to interpret to workshop personnel some of the rationale underlying the ILRP.

---

*The ILRP Project Director has served as Chairman since 1958.

An important advance in the State Department of Social Welfare was the liberalization in 1964 of the definition of "Aid to the Disabled" (ATD), to rehabilitate severely handicapped m.r. adults. This made it possible for persons such as those in state hospitals for the mentally retarded to be placed in the community, to receive subsistence grants, and to enroll in the ILRP.

The State Department of Education has been greatly interested in the ILRP for several reasons. During the past few years special education for the "trainable" mentally retarded pupil (I.Q. below 50) has become mandatory in the public schools. Potentially many trainable mentally retarded and certain more seriously handicapped "educable" mentally retarded would profit from the evaluation, training and counseling provided in a program like the ILRP, after completing schooling at age 18 years (or 21 years).

Local Influences on Project

The ILRP is a direct outgrowth of the Work-Training Center Project (1957-1961) which was sponsored by SFARC as a Selected Demonstration Project of VRA, with San Francisco Public Schools Adult Education support, cooperation by the State Vocational Rehabilitation Service, and other assistance.[8] By the end of the Work-Training Center Project in 1961, it had been demonstrated that m.r. adults previously considered unemployable, could be trained in a sheltered workshop to the level of being placeable on jobs in the competitive labor market in San Francisco. This rehabilitative function for vocationally feasible m.r. adults was assumed by the Morrison Rehabilitation Center, which in 1964 was reorganized. The Morrison Rehabilitation Center's workshop aspects were incorporated in a non-profit organization, the San Francisco Community Rehabilitation Workshop.

A second finding of the Work-Training Center Project was that certain m.r. adults could work productively in a long-term sheltered workshop. This workshop was originally sponsored and financed by SFARC, and in 1963, became a component of the S.F. Community Rehabilitation Workshop. The cost of services to this group is still financed by SFARC, with some support from ATD funds and S.F. Public Schools.

A third finding of the W-TC project was that there was a group of severely retarded adults who needed primarily a long-term program with a minimum of work and a maximum of socialization. This became the SFARC Adult Training Center, currently operated by SFARC.

During the Work-Training Center Project it had been noted that certain seriously handicapped retarded clients could have profited from intensive evaluation, personal and family counseling, and work-training which could have enhanced their personal, social and vocational competency, but that the W-TC did not provide for this type of service. The ILRP was specifically designed to furnish such services.

Reference has been made to the S.F. Community Rehabilitation Workshop (SFCRW), founded in 1964 to meet a need for the handicapped. Operated as a non-profit organization, with a Board of Directors representing community concern for the handicapped, the SFCRW currently admits adults including the mentally retarded, for short-term evaluation, for long-term work experiences and for limited vocational counseling. Contract work involving packaging, assembly work, etc. represent the major types of activity. One of the goals of ILRP in the later period of the project has been to explore closer relationships with the SFCRW.

An important development in San Francisco, in 1962, was the S.F. Coordinating Council on Mental Retardation (SFCCMR). This is a group of professional workers with an interest in developing community-wide services for all the mentally retarded. Initial support for staffing the SFCCMR came from the State Department of Mental Hygiene, through National Mental Health Act planning funds. Greatly accelerated activity resulted in committee work leading to professional educational institutes, to proposals for establishing an Information and Referral Service for the M.R. (founded in 1964 as a function of the S.F. Department of Public Health with a National Institute of Mental Health grant), and to a large scale five year Community Demonstration Project (funded by VRA). Members of the ILRP and SFARC staff have participated actively in all phases of SFCCMR efforts, including membership on committees, the Board of Directors and participation in its projects.

CHAPTER 3

OVERVIEW OF PROGRAM

Chart 1 represents in schematic form the flow of enrollees into and out of the ILRP. Starting at the top of the chart, most referrals come from a few sources. The application is then studied in the Intake process (see Chapter 6 for details), with possibility of either being admitted to the program, or referral elsewhere. Once admitted to the program, the enrollee is provided an individual "prescription" program appropriate to his needs, and his parents are involved in the program. Ongoing evaluation is provided through constant staff review. On termination from ILRP, the enrollee is transferred to another program. Arrows pointed in both directions indicate that he may return to ILRP and move out again, if necessary.

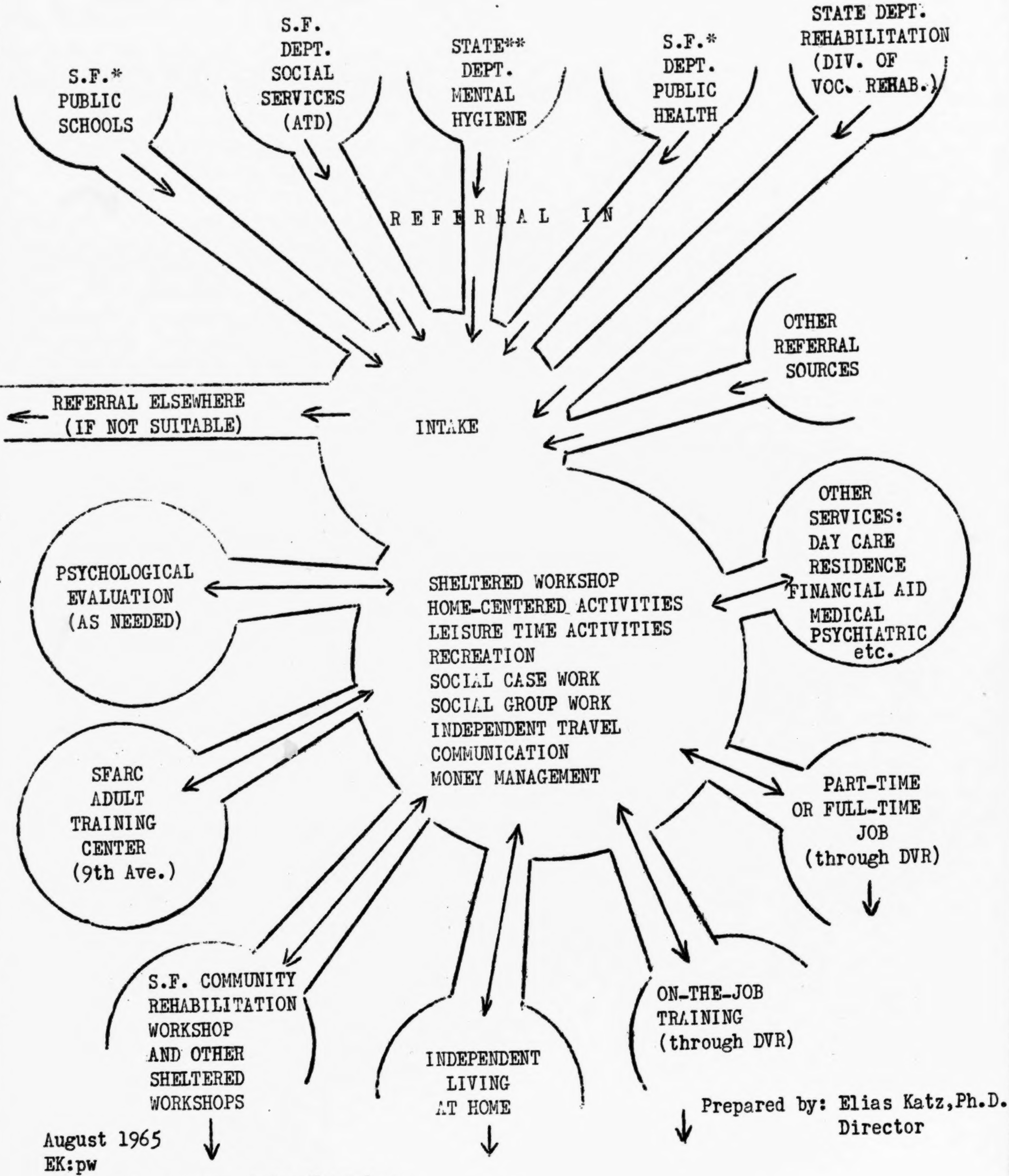
Eligibility for Admission

The broad criteria governing admission to the program may be stated as follows:

1. Chronological age 18 to 35 years. The lower age limit is established because the S.F. Unified School District conducts classes for the mentally retarded up to the age of 18 years. Although many m.r. students below 18 years of age drop out of school, or are excluded, the public school classes are available for them, and there is no intention to substitute the ILRP for available schooling. The upper age limit of 35 years was selected because previous experience in the Work-Training Center had demonstrated that older retarded adults (in their 40's and 50's) tended to be less flexible and amenable to change through the intensive program of the ILRP.[9]

2. "Seriously handicapping mental retardation", I.Q. below 70, as judged by properly qualified psychological and medical examiners. Although the phrase "seriously handicapping mental retardation" was derived from the "Independent Living" legislation, its use in this project is intended to stress not only the lower level of intelligence but the socially and economically disabling limitations of the enrollees. The selection of an arbitrary "I.Q. below 70" would tend to classify the retardate in the "mild","moderate", or "severe" ranges of mental retardation, according to the nomenclature of the AAMD.[10,11] The qualification that the enrollee's mental retardation be well established by tests implies that individual psychological testing and any

CHART 1. FLOW CHART - INDEPENDENT LIVING REHABILITATION PROGRAM


S.F.* PUBLIC SCHOOLS
S.F. DEPT. SOCIAL SERVICES (ATD)
STATE** DEPT. MENTAL HYGIENE
S.F.* DEPT. PUBLIC HEALTH
STATE DEPT. REHABILITATION (DIV. OF VOC. REHAB.)
REFERRAL IN
OTHER REFERRAL SOURCES
REFERRAL ELSEWHERE (IF NOT SUITABLE)
INTAKE
PSYCHOLOGICAL EVALUATION (AS NEEDED)
SHELTERED WORKSHOP
HOME-CENTERED ACTIVITIES
LEISURE TIME ACTIVITIES
RECREATION
SOCIAL CASE WORK
SOCIAL GROUP WORK
INDEPENDENT TRAVEL
COMMUNICATION
MONEY MANAGEMENT
OTHER SERVICES: DAY CARE RESIDENCE FINANCIAL AID MEDICAL PSYCHIATRIC etc.
SFARC ADULT TRAINING CENTER (9th Ave.)
PART-TIME OR FULL-TIME JOB (through DVR)
S.F. COMMUNITY REHABILITATION WORKSHOP AND OTHER SHELTERED WORKSHOPS
INDEPENDENT LIVING AT HOME
ON-THE-JOB TRAINING (through DVR)

Prepared by: Elias Katz, Ph.D.
Director

August 1965
EK:pw
*City and County of San Francisco
**State of California

other necessary evaluation would be done prior to admission or shortly after admission.

3. Capable of learning to travel to and from the program. If a client cannot travel to the program independently at the time of enrollment, there should be some prospect of becoming able to do so during the course of attendance. This criterion tends to make parents or guardians assume responsibility for making it possible for the enrollee to get to the program independently. (With some parents it is accepted that the fear of independent travel is realistic, e.g., poor sense of direction, immaturity, and no attempt is made to work with their feelings on this point).

4. Trained in toilet habits. Since no matron service is available, the enrollee is expected to be able to take care of his toilet needs.

5. Able to communicate with others. It is felt that the enrollee should be able to make his wants known and to understand directions. This criterion eliminates some multiply-handicapped persons who are not able to see, to hear, or to communicate properly.

6. Emotionally stable. It is recognized that many m.r. adults have emotional disturbances. The frankly psychotic, acting out, destructive person who presents realistic management problems is not enrolled, since psychiatric treatment is not available as part of the program.

Referral Sources

The sources of referral to the ILRP are relatively few:

1. San Francisco Unified School District. Students who have attended public school classes for the "educable" mentally retarded and for the "trainable" mentally retarded up to 18 years of age are referred by the school principal or by school counselors on "graduation" from these classes.

2. S.F. City and County Department of Social Service (formerly Department of Public Welfare). The caseload of clients in the Aid to the Disabled (ATD) category of public assistance includes many who are eligible for admission: mentally retarded persons over 18 years of age, whose disability is so severe as to render them unable to support themselves.

3. Division of Vocational Rehabilitation, State Department of Rehabilitation. Mentally retarded clients who (1) have been evaluated and found "not vocationally feasible", or (2) have been accepted for rehabilitation services and subsequently found "not vocationally feasible" for such reasons as poor work habits, are referred.

4. Bureau of Social Work, State Department of Mental Hygiene. Patients on leave from the State Hospitals for the mentally retarded (the nearest is Sonoma State Hospital, 55 miles north of San Francisco) are supervised in San Francisco by social workers attached to the Bureau of Social Work, Department of Mental Hygiene. Most of these patients are living in family care homes, licensed by the State Department of Mental Hygiene.

5. S.F. City and County Public Health Department, Community Mental Health Services. The Community Mental Health Services refers (1) eligible m.r. persons on the waiting list for Sonoma State Hospital, and (2) m.r. patients who might be in psychiatric out-patient treatment in one of the clinics conducted by the Community Mental Health Service. Several referrals have been made by Public Health Nurses, especially following the program on Mental Retardation conducted in January, 1964, in which the ILRP was discussed by the nurses.

6. S.F. Aid Retarded Children Adult Programs. Early in the project period (1962), a few referrals were made to ILRP from the SFARC Adult Training Center (more severely retarded group). Some referrals also came from the SFARC Work-Training Center (less severely retarded group), (1962 and 1963) during the period prior to the incorporation of this group into the S.F. Community Rehabilitation Workshop.

7. Miscellaneous Sources. Several referrals have come from Family Service Agencies in San Francisco. A few referrals have come from individual physicians, from medical clinis and on the basis of newspaper stories.

In a few cases, especially referrals of patients on leave from Sonoma State Hospital, more than one referral source is involved, for the patient is not only on leave from the State Hospital, but also is an ATD client of the City and County Department of Social Service.

CHAPTER 4

DIRECT SERVICES

The direct services to enrollees are work training and social casework services and social group work services. Families are provided with social services in intake and while enrollee is in the program. In addition, psychological testing is done on all enrollees shortly after admission, if such testing has not been done recently.

From the beginning of the project it has been recognized that the enrollee is a part of a family unit. While the focus of service is the enrolled client, counseling is provided for parents or responsible relatives insofar as their attitudes and behavior affect the enrollees, thereby extending this focus to the larger family unit. Exceptions to this are those enrollees who are patients on leave from the State Hospital for the retarded, and who are living in foster homes, or boarding homes, without family ties in San Francisco. During the project, no social services were provided for family caretakers in whose homes enrollees on leave from the state institution for the retarded were living. This represents an important question requiring future investigation.

Rehabilitation Team Approach

A conscious effort has been made to develop and to maintain a rehabilitation team approach in dealing with the day-to-day activities affecting individual enrollees, in relating information about the enrollee outside the program with what is happening to him while in attendance, and in long range planning. This has meant employing well-trained and experienced personnel*, delegating responsibility to them, and insuring a flow of communication among all staff members, as well as between this program and other agencies involved in meeting the enrollee's needs. These include the State Department of Mental Hygiene, the State Department of Rehabilitation, City and County Department of Social Service.

There is general agreement among staff members as to goals and planning for individual enrollees and family members, subject to modification as the enrollee changes while in the program. The initial daily assignment is the product of staff discussion and subsequent changes in schedule are discussed and evaluated. As described in a later section, although the Training Staff and the Social Service Staff have relatively distinctive roles, they complement each other. The staff meets as a whole once a week to review cases for one hour and to participate in weekly one-hour psychiatric consultation. Each morning a brief meeting of 20 to 30 minutes prior to the day's work brings the staff together to discuss matters of immediate concern, including behavioral and management problems of enrollees. There are opportunities for informal contacts as staff members meet each other at lunch, coffee breaks and elsewhere to share thoughts about clients or other matters. In addition, the Social Service Staff, the Training Staff, the Social Work Students, each have their weekly meetings, as do the VISTA staff.

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*Project Director, Clinical Psychologist with Ph.D.; Coordinator of Training, M.A. in Rehabilitation Counseling; Chief of Social Services, M.S.W., etc.

Initial Evaluation Period

Although evaluation of the enrollee is an ongoing concern of the staff, the first eight weeks after admission are an intensive initial evaluation period. The purpose of this period is to study the new enrollee at work, at play, in social groups, and in individual interviews, to engage participation by the parents or guardians, and to arrive at a staff decision as to whether or not the enrollee would profit from continuing in the program for the stated maximum of 2 years' attendance.

From the first day, the enrollee is given a daily schedule which is followed along with all other enrollees, and is assigned to a Social Worker for case work interviews. During this period the parent or responsible relative is seen regularly by the Social Worker.

At the end of the eight week Initial Evaluation Period, a Staff Case Review is conducted. At this session, the Social Worker presents a summary of the history. All staff members who have worked with the enrollee, present orally their observations and evaluations as to the strengths and limitations of the enrollee and his family. A staff decision is made as to whether the enrollee should be referred elsewhere or should continue in the program. (This Initial Case Review is also the occasion for the first administration of the ILRP Social Competency Ratings (see Chapter 9). It should be emphasized that the ILRP Social Competency Ratings are independent of the case review decisions).

If he is to remain in the program, specific long-term and short-term goals are formulated and methods for attaining the goals are discussed. Since there may be differences in enrollee relationships to individual staff members, this may also be discussed and adjustments made. If the enrollee displays some specific behavior difficulty, such as irritability, withdrawal, infantilism, this may call for a joint staff approach involving all or part of the staff in dealing with the problem.

Written reports by each staff member are also prepared. These are compiled for circulation to the total staff and for inclusion in the enrollee Case File. If during the Initial Evaluation Period, the staff arrives at the decision (occurring in only 2 or 3 cases) that the ILRP is not appropriate for the enrollee, the Social Worker assumes responsibility for helping the enrollee and family move out of the ILRP and seek assistance elsewhere.

Daily Schedule

The daily schedule for each enrollee crystallizes the direct service aspects and reflects staff concern for goals and progress. This is accomplished in two phases. The first phase occurs on admission to the program when each enrollee is assigned a schedule including two hours in the Sheltered Workshop, one hour in Leisure Time Activities, one hour in Home Centered Activities, one hour in the "Lounge", one half-hour for lunch. (This was modified somewhat after September 1965, when the ILRP moved from 1680 Mission Street to 475 Brannan Street, where there was no space to carry on the "Lounge" and only a limited space for the Home Centered Activities.) Assignments are made to regular interviews with the Social Worker, as well as to social clubs or other group activities. The second phase occurs when adjustments in the schedule are made to meet individual needs, as staff members get to know the capabilities and limitations of each enrollee. For example, if an enrollee can profit from additional time in the sheltered workshop, his schedule would be changed accordingly.

Such a daily schedule provides structure and defined limits which many retarded persons find comfortable. It also makes for flexibility in adjusting to individual needs. For example, if more time in the Home Centered Activities will be helpful to the enrollee, his time in other activities can be cut down to allow for this.

From another viewpoint, staff members have characterized the daily program as a reflection of the community itself, by providing the enrollees with opportunities to work and to earn, to learn skills and work habits, to socialize, to receive guidance and counseling and to gain acceptance as citizens.

CHAPTER 5

TRAINING PROGRAM

Introduction

The training areas are designated as "Workshop", "Leisure Time Activities" and "Home Centered Activities". In addition, pre-vocational training is provided in Janitorial Services and Messenger Services. Since the VISTA[12] (Volunteers in Service to America, United States Office of Economic Opportunity) Staff became available in the Spring of 1965, it is possible to enrich the established program to include more intensive individual tutoring in reading, writing, arithmetic, money-changing, travel-training and personal grooming.

Workshop

The Workshop aims to evaluate and to develop work skills and attitudes through the medium of contract work similar to that used in other sheltered workshops. The types of work range from simple to complex sorting, packaging and pre-assembly. Most of this work is sub-contracted, in the sense that the contractor, usually a manufacturer or distributor of products supplies the component parts, while ILRP provides the labor in the form of work by the enrollees under staff supervision.

At times, especially before a steady stream of contract work was provided by the SFCRW, it was possible to enter into the area of prime manufacture of such items as Christmas ornaments and decorations, and beeswax candles. In this situation the ILRP invested in supplies, provided the enrollee manpower, and sold products directly to the consumer, mostly at a special Christmas Sale. Needless to say, if this arrangement were to be expanded into a full scale manufacturing activity, it would require careful analysis of the investment and return, since there is a considerable difference between the small-scale operation involving sales to a limited group and a large-scale commercial enterprise on a volume basis.*

The Workshop Staff works toward improvement of the enrollee's self-image as a worker, while providing instruction in the performance of specific work assignments. Emphasis is placed on concentration, improvement of motor skills, and on work tolerance. This calls for staff supervision of a highly individualized nature as well as careful attention to presentation of job operations in units which can be handled by each enrollee.

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*The Kennedy Foundation, VRA and National Society for Crippled Children and Adults are developing a national program for workshops to manufacture and to market candles.

Enrollees are paid a salary based on productivity in relation to norms based on the performance of non-handicapped workers at the same task. A "minimum wage" of 15¢ per hour has been established for time spent in the Workshop, with salary increases based on productivity as measured by the staff. In some enrollees productivity is below 15¢ per hour. Authorization for paying wages below the Federal minimum wage is provided under a certificate issued to ILRP as a Sheltered Workshop by the U.S. Department of Labor, Division of Wages and Hours.

As in other work situations, efficiency of operation in the Workshop is sought in order to bring about greater quantity and improved quality of output. Industrial engineering methods, including factory layout, production control and appropriate distribution of personnel (staff and volunteers), are brought into play wherever possible to improve the relatively small volume operation of the Workshop. Where needed, the State Department of Rehabilitation's Workshop Consultant provides consultation in these areas.

Leisure Time Activities

The Leisure Time Activities are designed to provide an area in which enrollees might explore media by which leisure time could be enriched through productive and enjoyable pursuits. This activity is also useful for purposes of evaluation and training in good work habits and social adjustment. In addition, skills gained or enhanced here could enable the enrollee to make worthwhile contributions to family or group living situations, by being able to carry on his hobbies at home independently or with minimal supervision. This could free family members to pursue other activities, and allow him to make a positive contribution of his own to the family group in the form of a creative product.

This training is carried out in an informal, relaxed atmosphere, with activities varying in levels of dexterity, skill, concentration and creativity to suit individual needs.

Activities include simple leather work (cutting, punching, lacing, etc.), sewing (including pattern sewing, repair and alterations), copper tooling, rug making, wood carving, embroidery, knitting and petit point, mosaics, care of pets and house plants, furniture repair and refinishing, and construction of Christmas ornaments and decorations.

The last two activities on this list deserve special mention. The furniture refinishing was so popular, and the results so dramatic, that a small business developed in which enrollees undertook stripping refinishing and restoration of furniture for an enthusiastic public. One of the basic values of the furniture refinishing is the opportunity for the trainee to feel the real sense of accomplishment which comes from seeing the total process involved in his work, from stripping to the final oiling and waxing.

The Christmas ornaments and decorations, developed in the Leisure Time Activities, met with such demand in two successive years that their production was moved into the Workshop where assembly line techniques were used in their construction. This activity also enabled the enrollee to see the total work process: to buy the materials, create the product, and then sell the ornaments to the consumer. Some of the parents became interested in the work and inquired about continued production at home for the benefit of both family and friends. Thus the construction of Christmas ornaments met with double success - as a good Workshop contract, and as a valuable leisure time activity which enabled the enrollee to contribute to the beauty of the holiday season.

This development in leisure-time activities which in some instances may lead to partial or total self-support has many implications in pre-vocational training of the retarded adult.

Home Centered Activities

The major goal of the Home Centered Activities is to develop skills applicable to every day life at home. Initially it was postulated that some of the enrollees would eventually be living at home full-time, and the ILRP would prepare them for this by providing necessary knowledge and skills useful in the home. As the program progressed, it became clear that some of the enrollees were benefitting beyond expectations from this training. As a consequence, more emphasis was placed on developing the home centered activity to include pre-vocational training and possible job placement. The stress is on helping the enrollee develop skills which could be used in the home, or in an actual job setting.

The area available (up to August 1965, when the ILRP moved from 1680 Mission Street, to 475 Brannan Street, where limited facilities for this purpose are available) included a kitchen, bedroom and bathroom. The bathroom was a mock-up bathroom, originally designed for training physically handicapped persons. The furnished bedroom permitted enrollees to practice bed-making, dusting, vacuuming, waxing, and general cleaning. The center of activity was a kitchen which included stove, sink, refrigerator, cabinets and a dining room table. Here enrollees prepared their own lunch, stored food supplies, learned to set the table, wash dishes, defrost the refrigerator, handle and care for kitchen equipment as found in the average home. Each week daily menus were prepared by enrollees. Twice a week a shopping trip was made to nearby markets (a super market and a small neighborhood grocery) to purchase the necessary items. In this connection, it was possible to determine which enrollees could read labels of cans and boxes, make change, and tell time. The program provided functional elementary instruction in these matters for those who needed it.

The daily schedule of the kitchen started with food preparation during the first hours, continued into food serving during the lunch period, and ended in cleanup and preparations for the next day during the afternoon. The principles of efficient use of time, materials and personnel were carefully observed, focussing on the development of good work habits in enrollees.

In the early period of the project, the Home Centered Activities were supervised by a female staff member. Later a male staff member supervised. The selection of a man to carry on this activity was intentional. This was done to "provide masculine identification of home centered activities for men who might be living at home - or in a setting where these skills would be contributing", to quote the ILRP Coordinator of Training.

Since September 1965, activity has been limited to making sandwiches for lunch. This has meant almost total elimination of such activities as shopping for food used in hot lunches, training in other homemaking activities such as bedmaking, ironing, laundering, etc.

As a permanent location of the program is established, it is anticipated that Home Centered activities will again be strengthened.

Pre-Vocational Training: Janitorial Work

Janitorial Training is designed to develop the enrollee's skills so that he might some day obtain part-time or full-time employment where such work would be a portion or all the job.

The enrollees usually work two hours a day (one in the morning and one in the afternoon) at tasks required of most janitors. The enrollee is paid 35¢ per hour for this work.

The usual morning schedule is:

(1) Empty wastebaskets.
(2) Clean ash trays.
(3) Dust chairs and desks.
(4) Sweep floors.

In the afternoon the following schedule is followed:

(1) Clean toilets and face bowls.
(2) Fill all paper and soap dispensers.
(3) Mop restroom floors.

Whenever a new enrollee begins janitorial training, he is not left alone to carry out the task. It has been found that the enrollee is more responsive if the staff member helps at first. Later, the staff member's participation is not as active as it was during the first few weeks.

The supplies and equipment used are the same as those used on a regular janitorial job. The enrollee is responsible for keeping all equipment clean.

If necessary, when an enrollee obtains janitorial work outside the ILRP he is accompanied by a staff member to and from the job for a week or two. The staff person trains the enrollee in travel and supervises on-the-job during an adjustment period.

With the assignment of VISTA Volunteer Staff in the Spring, 1965, it has been possible to expand the janitorial training service in travel training to and from the job, with VISTA Staff assisting.

Prevocational Training: Messenger Work

The physical separation of the several programs conducted by SFARC offers the opportunity to train ILRP enrollees to perform intra-agency messenger assignments using public transportation. At the beginning of the project, the six-mile trip from 1680 Mission Street to the SFARC office at 1362-9th Avenue, did not require a transfer and the enrollee had a choice of several busses as well as the streetcar. Initial trips were made with trainers, usually a staff member, or trained volunteer. As the enrollees have grown in confidence and dependability, they have been able to make the round trip unattended, carrying important inter-office mail. The move to 475 Brannan Street in August 1965 has added a bus or street car transfer to the trip and increased the complexity of the demands. Later, training for a still more complex messenger service has been installed, requiring a messenger to report to

1362-9th Avenue, to carry the mail from there to the SFARC Pre-School Program at 2665-28th Avenue, and then to return to 475 Brannan Street.

Messenger service is paid at the rate of 75¢ an hour and requires approximately two hours twice a week. It not only provides travel training for selected trainees but provides the motivation of a salary increase and assists in the formation of better work habits and attitudes. Early changes have been noticed in the enrollee's efforts to develop prompt and efficient service; increased reliability and attention to detail emerge as training progresses.

Tutoring

Many enrollees need tutoring and remedial work in basic elementary school subjects, including reading, writing, arithmetic, as well as in improvement of communication skills, money management, independent travel, and personal grooming. Unfortunately, limitations of staff time have prevented the development of extensive training programs for this purpose. Intermittently, programs were carried on through the help of volunteers and graduate students in personal grooming ("Look Your Best" Group") and travel training. When the VISTA volunteers were assigned in Spring, 1965, a greater opportunity was provded for tutoring.

(1) Reading

The purpose of the reading program is to develop functional reading skills, such as reading and writing of names and addresses; reading of safety signs; and reading of words and phrases used in the Workshop, Home Centered and Leisure Time Activities, as well as in traveling around the city and to work assignments. The more advanced students are trained in reading for pleasure.

The Coordinator of Training had for many years been a classroom teacher of handicapped children, and supervises volunteers. In addition, consultation is available through the Department of Special Education of San Francisco State College.

(2) Communication Skills

The incidence of serious speech defects in the ILRP population is high. While some attempts were made to improve speech in the course of reading tutoring, the poor communication pattern of many enrollees had become so firmly entrenched that to bring about significant changes would have demanded far greater efforts than were available. Basically, the staff provides the model for clear, intelligible speech in everyday contact, and insists that each enrollee express himself to the best of his ability.

(3) Money Management

The purpose of training in money management is to develop some appreciation of the significance of money as earned income and for buying things. Each enrollee receives the minimum "salary" bi-weekly (15¢ per hour spent in the sheltered workshop), regardless of level of productivity, with higher productivity yielding higher wages. Payment is made by check.

Payment by check means that the check has to be cashed, unless it is deposited in a bank. If the check is cashed, the enrollee has money available. Since the earnings from ILRP work are insufficient to cover living costs, most enrollees receive financial support from other sources, whether from public welfare or from their families. Most spend money on transportation and meals, as well as for personal items like clothes and entertainment. Under these circumstances training in money management is of direct value to each enrollee.

Efforts to provide such training are carried on in several areas. For example, shopping for groceries to be used during lunch provides opportunities to pay the clerk and receive change. On several occasions, ILRP social clubs set up procedures in which club members were charged dues to pay for refreshments at parties run by the club. After the VISTA Volunteers arrived in Spring 1965, a more formal training program developed, with regular lessons in handling money.

(4) Independent Travel

Training in independent travel is stressed from the beginning of contact with the applicant. In fact, one of the criteria for admission is that the enrollee be able to come to the program without help, or be capable of being trained to do so. Whenever possible, enrollees are encouraged to travel, whether in relation to the program, such as in purchasing food for lunch and making trips to visit prospective jobs, or in after-hours activities, such as visiting relatives, or attending circus and other recreational experiences.

Training in messenger work, as described above, has brought a vocational orientation into independent travel.

(5) Personal Grooming

Training in personal grooming for ILRP enrollees is concerned with dressing and grooming appropriately during the work day within the program, and dressing and grooming for other occasions. Many enrollees are living in homes where the standards of dress are poor. Some have lived in State hospitals for the retarded for many years, where they had little responsibility for maintaining their own clothing, and were not prepared for the experience of having to look presentable in public.

Groups have been formed to train enrollees in such matters as hair care, appropriate clothing and cleanliness. A major approach to this training is by staff example of appropriate clothing and grooming for daily activities.

CHAPTER 6

THE SOCIAL SERVICE PROGRAM

(The following chapter was prepared by Arthur Segal, MSW, ILRP Chief of Social Services, and Field Work Supervisor, University of California School of Social Welfare).

Social Services in the ILRP are observed on several levels. These include the enrollee and his family, the staff and the agency, community organization and professional training. The primary goal on each of these levels is to effect social change within these groupings - the family, the agency and the community, so that the enrollee may participate in these environments as a more productive and self-sufficient individual. This goal can also be stated in terms of helping the enrollee and his family use each other in a more constructive way and to gain from the community, from the agency and from San Francisco the maximum these have to offer (or can be helped to offer).

The methods used by the social worker are those of case work and group work with enrollees and their families; interpretation to the staff of enrollee and family social and emotional needs and strengths; and sharing of professional knowledge about the needs and strengths of the mentally retarded with the professional community. The method of sharing knowledge with the community and helping other groups develop services is used by all agency staff and is described elsewhere in this report (see Chapter 8).

Social Service with the Applicant and his family prior to admission: Intake

The receipt of an application for admission coming from an agency or the family triggers Intake into operation. (The Intake procedures are handled for the most part, by the Chief of Social Service). During the next period of time the social worker meets with the family to help them consider their needs and their goals, and to relate these to the aims and functions of the ILRP. Within this framework the family is helped to decide about entering the program. The applicant and his family are seen both individually and as a group during these first interviews. They are helped to pull together previous medical, social and educational experiences for the purposes of evaluating need and eligibility for the program.

The family group is told during these first interviews of the requirement that they all participate in the social work program. This requirement is interpreted in the following terms: "Having a mentally retarded child poses many problems to families and many questions go unanswered. Families are, as a result, often uncertain as to what they can expect from each other and their misunderstandings may create additional problems. The family meetings are to help members unravel some of these confusions."

The social worker goes on in his interpretation somewhat as follows: "The enrollee will have experiences at the ILRP which he will reflect at home through questions or new kinds of behavior reactions. We think that the experiences we refer to are generally anticipated by parents who have young teenage children; however, your children are young adults and you may question these earlier developmental experiences at their present age. During our meetings we will discuss your son's (or daughter's) experiences here and at home."

During this period needed aid such as financial, medical, household or psychiatric may be noted. The family is helped to explore these other needs and the available community resources which might provide the appropriate assistance. Arrangements are then made for admission to the program. These might include travel training and discussing requirements for daily participation. The applicant would then be placed on a waiting list with some indication as to an admission date.

Use of Referral Material

The social service staff uses two primary methods in evaluating and predicting the applicant's ability to use the ILRP. These are interviews with the family and case material from other professionally trained workers who have served the enrollee. The results of these two methods are frequently futile.

The interview has been found to be the more useful of the two methods. It provides some insight into the applicant's skills and limitations as seen by himself and by his parents. The interview also permits the intake worker to observe the family social interaction and to evaluate the applicant's role in the family; however, the interview does not help predict the enrollee's ability to use the program. The reasons for inability to use intake interviews as a tool for prediction are based on the following observations:

The applicant may be fearful of the new situation. This emotion may have been encouraged by his parents who told him "to behave" so he could get into the program.

The applicant may see the program as "work" and may say the "right things" so that he can "get the job".

The applicant's previous experiences in school or the State hospital may be within a frame of reference which cannot be applied to the ILRP. He may be coming from a relatively controlled environment into a relatively permissive environment. His reactions to the new environment may reflect previous experiences but may change as he forms new kinds of relationships with staff and with peers.

The usefulness of case material from referral sources is very much related to the writer's frame of reference. Thus a report from the State hospital which states that Joe K has "worked very well" in the institution's kitchen cannot be generalized to predict that he will work well in a San Francisco cafeteria. A report from a school stating that Mary J. "cooperated with her classmates" in a setting which does not allow for independent socialization does not permit us to predict how she will relate to peers in a setting where socialization and independent problem solving is encouraged. These reports help us to gain knowledge of the applicant's background and to guess at his possible reactions. We cannot use them as tools to predict accurately the applicant's ability to use the ILRP.

The most useful case material is of a factual nature, medical reports, reports of academic ability and achievement, intellectual skills. Psychiatric reports from the State hospitals are usually summarized to a point of vague generalizations leading to a diagnosis. These have been misleading and could not be used. Some psychiatric reports from the State hospital offer little more than admission and discharge dates.

The Application Review

The whole ILRP staff meets to review the application, following the Intake interviews, study of case material and discussion with the Project Director. The purpose of this meeting is to permit general evaluation of the applicant's ability to use the ILRP and to form a decision as to his admission. During the early months of the project, the staff attempted to arrive at these decisions based on the available referral material; however, this task was complicated by the factors mentioned above. Staff attempts to use the referral material as a tool to evaluate and to predict the applicant's use of ILRP were frequently frustrated on later discovery that the enrollee who had been evaluated as a "risky" applicant had somehow "blossomed" after several months, while other enrollees who during Intake presented positive referral material evidenced unanticipated behavior problems. These observations have encouraged experimentation with the admission decision and have led to admission of several applicants who might have been refused on the basis of referral material indicating "inability to grow" or "inability to use help". Some of these enrollees have "made good" and have moved into other workshop programs and on to jobs.

Some families after exploration of the ILRP have refused service. This refusal is related to several factors:

(a) Family denial that the child is "as retarded" as the others in the ILRP.
(b) Family refusal to participate in the social work program.
(c) Family's inability to arrange for transportation of their child to and from the program. The family's difficulty in this area was not always solved by the social worker. In some families both parents worked and could not help with travel training. In other families a complicated transportation route, coupled with parental apathy and discouragement hampered admission.

When the application procedure is terminated due to the family's refusal of service or because their child does not meet eligibility requirements, social service is continued to help the family return to the referring agency or to help them investigate other community services.

Social Service with the Enrollee and his Family after Admission

The need for socialization and peer relationships is a basic one if the child is to grow to the man and to participate in a democratic society. A child isolated from his peers is deprived of a vital experience and this deprivation breeds confusion about the community. This child lacks the social learning required for sharing daily experiences with others. He lacks the ability to plan with others, and to share responsibility for his actions. He is not sure of his role in the daily give and take with peers and with family. His frame of reference for normal behavior may be taken from a television series or from the controlled community life of the State hospital. Each reference point may be at variance with the expectations of his present community in San Francisco.

The families of the retarded have faced their conflicts by adopting their own form of isolation. Some families have broken away from friends and relatives. Others use defense mechanisms of denial to isolate the child's handicap from conscious awareness. To some extent most families have isolated themselves from constructive guidance and planning for their handicapped member. The family isolation, though not identical to the child's isolation, has a similar effect. The family, too, is deprived of a relationship with all the resources of the community. As a result of this isolation the family may focus unduly on conflicts and disabilities and may magnify problems of interrelationships.

The social work focus is on helping the families clarify some of their confusions in roles so that the members may resume a more active and productive participation in both the internal family affairs and the larger community affairs. The worker uses specific methods aimed toward helping enrollees and families come together for purposes of sharing a group experience. The goal is that these groups will grow strong and during this process the individual members will learn how to live with each other; that the individual enrollee and his parents will resolve some of those conflicts of an interpersonal nature and will grow in the direction of greater emotional security.

The enrollee has many concerns and wants to share these with the social worker. The more general concerns brought to the group meetings and to the interview fall into the following categories:

1. "Why am I retarded?"
2. "Why do people stare at me and treat me differently?"
3. "My parents treat me as a child."
4. "My parents call me lazy."
5. "I want to get married, have a job and drive a car."

The more specific questions are comparable to questions brought by most non-retarded youth to an adult counselor. The enrollee is quite aware of his role - as it has been defined by the parent or adult authority figure and he uses it to his advantage. He also wants, however, to identify with the non-retarded adult and this creates conflict. It is this conflict which the social worker and the enrollee share as they work together. The conflict presents itself frequently and in many forms. "What kind of games shall we play and are games childish?" "Shall we sing on the street or on the bus?" "Can we go on a swing?" In their effort to create an adult image, some enrollees must reject activities which the average adult enjoys and with which he feels comfortable. Thus we see rejection of certain group games and leisure time activities.

The job of the social worker is to teach a model of adult behavior. He must also help the enrollees learn about and understand the values expressed by those about him. This includes peers, staff, family, merchants, bus drivers, etc. The problems encountered most frequently as we attempt to present the real community are those of confusion, misinformation, and maladaption due in part to isolation. The social worker tries to help the enrollee re-learn in the area of social behavior by helping him focus on his present behavior and to question the reactions produced in the staff community - by praising that behavior which produces positive reaction and questioning that which produces negative reactions.

Treatment Methods with Enrollees

The Social Club Group

The social club group is patterned after similar units in recreation centers, churches, schools and large families. Their function is to create within a protected setting the opportunity for the enrollee to explore the interpersonal relationships and his role in these relationships. There are three such groups meeting one hour each week. The enrollee, after he has been observed for two weeks in the daily program, is placed in one of the groups. The selection of the club is determined after an evaluation of the enrollee's social maturity, the emotional level at which he relates to his peers, his recreational interests and the friendships he has formed in the ILRP. Mental age is not a factor considered for the placement.

The evaluation is then extended to the group and its members. How will the newcomer affect them and they him? Will the experience in the group be a positive one or a negative one? This latter question must be directly related to the goals for the individual. We need to consider the possible group reactions which will effect social learning and growth and then place the enrollee in an appropriate group.

The concept of group structure and group goals is familiar to enrollees in terms of the "power structure that be", the status quo as previously defined by parents, teachers or hospital ward personnel. Most have had little opportunity to share in the development of a group and must first be guided in this direction. As noted[13] the worker's first task is to help members talk to each other within the framework of a group purpose. This may be on the level of "what shall we do today?" or on the more complex and abstract level of project planning which will require several meetings for completion. The social worker's role may be more active during the stages of group formation. The members attempt to make him the focus of activity for reasons of lack of group experience and testing the limits of the worker. The worker accepts this central role long enough to help members move into a group structure, establish roles for themselves and start to develop interpersonal relationships. He begins to move away from this central role during the first meeting and continues to do so until the group is able to handle its own affairs. He moves into the group via interventions when he observes the group or individual group members in a conflict they cannot resolve independently.

Use of Program Media

Activities such as games, music, dancing, dramatics, etc., are more than just fun for the participants. Each has a social value and may be used to help enrollees resolve interpersonal conflicts. A ball game demands a structure and the group must enforce rules if the activity is to succeed. Dramatics in the form of role play permit group members to act out on each other the fears and conflicts they may not openly express. They can later discuss these conflicts and learn ways of handling them. The social worker uses activities on the basis of their value to the group as a whole and to individual members. The activity is a tool used in the treatment process.

Special interest groups are formed in an effort to provide additional social experiences of a specific nature. A newspaper group has weekly meetings and publishes a monthly newspaper. Members contribute stories about activities in and out of the program. They interview their peers, staff and volunteers. They editorialize on specific issues and review each article before it is accepted. Though the paper is scheduled for monthly publication there are no rigid deadlines. The socialization process and the effort to resolve issues overshadows the deadline in importance.

A group of men and another group of women meet each week at a nearby gymnasium. Though these groups are large and this factor decreases the effectiveness of group discussion some group planning and group limiting does take place. This is encouraged and planned for by the social worker.

The Enrollee Council

The Enrollee Council was created during the early period of the project to give enrollees an opportunity to assume some responsibility for developing their own norms and for assuming responsibility for their participation in this structure. This group was composed of two members from each of the three clubs. The members were elected and served for a term of six months. The Council met for two years. It was dissolved when enrollment in the ILRP fell to the point where the population was too small to warrant a special council. A smaller committee was formed to plan for special recreation programs in the Lounge. This group also creates rules for the Lounge.

The "Lounge"

The Lounge Hour is a daily activity open to all enrollees. The setting for this program is a large community type room, furnished with comfortable sofas and chairs, a phonograph with many current recordings, a ping pong table, cardtables and a variety of table games. There are empty corners in which one can "get lost" and a cold drink machine around which people can congregate.

The activities of the Lounge Hour are planned by staff and the enrollees' recreation committee. One of the popular activities is dancing and we have been fortunate to secure the volunteer assistance of the Arthur Murray Studio dance instructors for regular monthly dance instruction. Much of the time is left unstructured so that the enrollees can move out to games and to peer relationships as they feel ready to do so. They can also isolate themselves if they so wish.

The Lounge is staffed by two social workers and several student interns from the various school programs. We tried to have four staff and/or students present each hour. This is not possible each day of the week due to student schedules outside of the ILRP. The role of social workers during the Lounge Hour is to prepare the room and the activities so that they are available and then to move out to the fringe of the room. The social worker intervenes when he thinks a particular enrollee or group of enrollees needs him. The intervention may be to help start a small group activity or to settle a question arising out of such an activity. Most often the intervention is at times of crisis for a specific individual. Intervention of this kind is particularly helpful to the enrollee whose recall is poor and who has difficulty connecting past and present experiences and relating these to the future. "On the spot" intervention blocks defense formation and compels the enrollee to confront his behavior. (The Lounge Hour was temporarily discontinued after August 1965, since no space was available at the new location at 475 Brannan Street).

Individual Counseling

Each enrollee is assigned to a social worker who is responsible for pulling together a diagnostic case summary and for counselling sessions with the enrollee and his family. The enrollee soon learns to seek this person out when he needs assistance and brings many of his questions to his interview. Many enrollees have little ability to hold questions until their next scheduled interview, and will seek out a social worker during the day in order to share their concerns. If his social worker is not available the enrollee may seek out other staff members and attempt to confide in them. Thus one task of the social worker (with staff cooperation) is to help the enrollee control his concerns and to bring them either to the scheduled counselling sessions or to group meetings. The enrollee must also learn what type of question is appropriate to bring to either of these situations.

The scheduled interview is the social worker's way of saying "Please try to live with this until your next appointment". For some enrollees this wait is too difficult and more frequent and shorter interviews are scheduled. The enrollee who undergoes an emotional upset while in an activity, may, if possible, have immediate access to his social worker. If his social worker is not available, then another social worker will attempt an emotional first aid process on the immediate situation.

The one-to-one relationship of social worker to client is new to the enrollee. He may not know how to use the time with the worker and he may fear this person who is so concerned about him. He does not know what to say to the social worker nor does he know how to express those experiences he would like to share. The task of building a relationship with the client is of prime importance during the initial interviews. Recognizing that the enrollee may fear the office interview the social worker moves out of the office and into the daily activity program. He may meet the enrollee in the lounge, at the lunch break or in a setting familiar and non-threatening. He may play a table game with the enrollee or chat with him on a sofa. Game material may be moved into the office as a bridge for those enrollees who continue to fear this setting. The communication between worker and enrollee is the fundamental tool used and some techniques to stimulate verbalization have been explored. In addition to the mentioned game material, hand puppets have been used, giving one puppet to the enrollee and one to the worker. The two then speak through the puppets. Other means of dramatic play used are drawings to create stories. These are used for discussion in subsequent interviews.

The social work method of partialization[14] is of importance. The social worker must help the enrollee focus on one problem at a time or perhaps on only one segment of a problem. He must help the enrollee verbalize the problem in as concrete a way as possible. Some of the enrollee's disabilities lie in the area of concentration and piecing parts of an experience together into a meaningful whole. The interview is used to focus on daily experiences within the program and on questions brought by the enrollee. The experiences are discussed repeatedly [illegible] by incident and solutions worked through thought by thought. The thinking process when focussed on in this fashion becomes a model of how to resolve conflicts.

Treatment Methods with Enrollees and their Families

The enrollee is the client in the ILRP and the training staff attempts are focussed on individuals and groups of enrollees. The social worker by contrast has a broader focus. His goal is extended from helping the enrollee use the ILRP to helping him use his family and the community. The social worker directs his focus to the family unit which will absorb the enrollee and live with the enrollee. The family must be helped to do this as well as to maintain itself in a community which has a poor image of the mentally retarded.[15]

This concept of family participation is introduced to the family at the point of intake. The philosophy behind the concept is that the retarded member of the family, who lives within the family unit, is so emotionally tied to this unit that vocational maturation and emotional growth may be hampered and opposed by other members of the family. The effects of family opposition have been observed in the Work-Training Center Project, as well as in the present program. Staff of other agencies serving the mentally retarded and persons with physical handicaps have shared similar observations with the ILRP Social Workers. These observations lend weight to the requirement that families participate in Social Service while the retarded member attends the ILRP.

During the Initial Evaluation Period mother and father are usually seen together. When this is not possible, they are seen separately. After the initial Evaluation Period, there is a continuation of individual meetings, participation in a parent group or participation in a family group including the enrollee and perhaps other siblings or relatives. The selection of method is made by the social worker on the basis of an assessment of the family's needs, and an evaluation of the function of specific methods for that family.

Individual Casework with Family Members

Individual casework allows the social worker to develop an intensive relationship with members of the enrollee's family. Through this relationship the family member may be helped to explore the relationships he has with the enrollee, with other family members and his own emotional needs. This method is helpful to the family member who seeks a more intensive relationship with the social worker and has the strength to use this relationship. This method is also used by a parent who is not able to share himself in a family group or a parent group. Such a person may, through individual sessions, be helped to move into a group. Case work with individual parents is limited owing to the present limitations of available staff time.

Family Group Work

Family group work allows the social worker to see the enrollee's family interact and to confront them with their behavior. The defense mechanisms of individual family members are broken down by the family group, permitting the social worker to gain direct access to the family conflict and to help the family struggle with a solution to the conflict. A dramatic and effective experience is created when the social worker and the family participate together in a social affair. The affair is later discussed in terms of the roles each have played and their reactions to each other and the relationship to the enrollee's behavior and problems.

Parent Group Work

Parent group work has values for its members which are not duplicated in the family group. These are in the area of sharing the problems with parents of other enrollees and gaining mutual support. Parents learn from each other techniques of living with their handicapped adult child in the program. They can share family experiences and help each other seek solutions to family conflicts. This experience is especially valuable for those parents who have only one child. These parents do not have the opportunity to compare the development of their child with other children who are not mentally retarded. Having no guidelines for normal growth and development these parents may find difficulty and fear which the parent who has non-retarded children as well does not share. Thus for some the parent group can provide an educational experience.

For others the parent group provides a social outlet as well as a problem solving outlet. Parents who have isolated themselves from friends find new relationships and some of these last past the one-hour group meeting.

ILRP Social Services as One Part of a Network of Community Services to the Mentally Retarded

The basic social work concept "to help people help themselves" applies to the broad goal of helping individuals be more productive within their community as individuals, as family members and as citizens and carries implications of a job for staff beyond the walls of the ILRP. For if we assert ourselves in the direction of bringing the mentally retarded and their families into the social and vocational activities of the community we must also address ourselves to the task of helping the community receive our clients. The community in the form of the staffs in social agencies, recreation centers, schools and training programs, churches and clinics has at times shared with all of us the distorted image of the mentally retarded. This image needs to be corrected and illustrated in its proper dimensions of a total person with personality and intellectual strengths as well as deficits.

Social Service staff attempts to help prepare the community on two levels. Through participation in groups such as the S.F. Coordinating Council on Mental Retardation and the S.F. Mental Health Association the opportunity arises to present the needs of our clients and to enlist the aid of other professionals in reaching for a solution. Participation in professional institutes and conventions and publication of professional literature serves to reinforce the educational process on a larger community level. Invitations to consult with other agencies attempting to find answers to the questions we work with allow us to share our ideas and to discover new methods of treatment. Participation in such councils and educational programs lays the basis for long range assistance to the mentally retarded and to inter-agency cooperation needed to provide a continuum of services and to avoid duplication of services.

The interagency conference with the client as the focus is a most effective method of interpreting to other agencies the desired image of mental retardation. The conferences generally include both a tour of the ILRP and a sharing of ideas around ongoing treatment. Such conferences have encouraged greater understanding and cooperation between our staffs which has permitted an interflow of referrals, and a sharing of the treatment plan and process for some clients served in each of our agencies. (A discussion of Community Organization is presented in a later section. See Chapter 8.)

Social Work Education

The training of students is an obligation of professional agencies so that new workers are prepared to bring to their communities new methods and knowledge. This training task is especially important for agencies serving the mentally retarded. For where can a student learn how to help individuals who are mentally retarded if he is denied access to the few agencies which can serve as a service model?

During the project period, the ILRP has been the only community-based program in the greater Bay Area serving the mentally retarded which is training social work students. The ILRP and Sonoma State Hospital are the only two agencies in Northern California which offer field work placements to social work students who wish to learn about mental retardation.

The ILRP offers placements to a unit of four graduate social work students from the University of California, Berkeley. These students have assignments similar to those of regular social work staff. Their assignments involve use of group work, case work and community organization methods. Supervision of the students during the first two years of the project was shared by this agency and the university. This task was taken over by the university in the fall of 1964 when they assigned their faculty to the ILRP to teach the four-student unit. The unit continues this year and may be enlarged in the future.

The social work staff also offers placements to undergraduate social work students from San Francisco State College. These students are supervised by the social work staff. They work directly with the enrollees and their families though their assignments are not as intensive as those of the graduate student.

The advantages of this training program go beyond the assistance provided to the individual students. Other agencies such as the San Francisco Department of Social Services and Family Service Association have given assignments to their social work students which involve mentally retarded individuals. Students placed in these agencies have been able to use the ILRP students and staff as resources and consultants for the questions which arise in their work.

The ILRP has offered social work field work placements for 18 graduate social work students and 8 undergraduate students during the project period. A survey of the undergraduates indicates that two or three are now in County Departments of Social Service, one is in the Peace Corps, two plan to go into Departments of Social Service, and two are not accounted for. A survey of the graduate students who remain in the Bay Area indicates that one started a program for adolescent girls and uses a nursery school for the mentally retarded as a service project, one is at the YWCA and makes frequent use of ILRP for consultation, a third wishes to find employment with the mentally retarded, and a fourth is with a County Department of Social Service. Four students are currently at the ILRP, and of the unit placed last year three are in their second year of studies. Two of these students enrolled in a group research project on mental retardation.

(A discussion of other phases of professional training in the ILRP is given in Chapter 7.)

CHAPTER 7

SUPPORTIVE SERVICES

The term "supportive services" refers to those aspects of the ILRP which do not provide direct services to enrollees or their families, but which are an integral part of the total program.*

Professional Consultation Services

A Psychiatric Consultant is provided by the S.F. City and County Public Health Department's Community Mental Health Services on a regular basis. Initially, this was one session per month, later increased to two sessions per month, and since 1964 to one session per week. These consultations are attended by the ILRP staff, professional internes in Social Work and Rehabilitation Counseling, and VISTA Staff. At each session the emotional problems presented by various enrollees as individuals and as groups are discussed and reviewed. In view of the occasional severe disturbance present in enrollees, these discussions prove helpful in developing a course of action for dealing with the problem, or in evaluating the effectiveness of methods which have been used.

Important issues underlying the therapeutic approach in the program are frequently discussed. Finally the Psychiatric Consultant presents occasional didactic material on mental mechanisms, diagnostic problems and psychiatric procedures.

The four psychiatric consultants who have served in this capacity vary considerably in their training, orientation and ability to relate to staff members. Conversely there is a wide variation in staff members' readiness to accept and to use the services of a psychiatric consultant. This suggests that in-service training in the best use of a psychiatric consultant would be helpful for those staff members who wish to profit more from such consultation services.

The Medical Consultant meets with the staff on a monthly basis to review medical problems presented by enrollees. Consultations center on the nature of the medical condition and its effects on the ability of enrollee to perform in this setting. Didactic presentations have been devoted to brain damage and mental retardation and to the influence of drugs on behavior. The Medical Consultant is also helpful in referral of enrollees to medical clinics.

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*This terminology from AAMD monograph "A Manual on Program Development in Mental Retardation".[16]

The State Department of Rehabilitation's Chief Rehabilitation Workshop Consultant provides industrial engineering consultation on request. This has been helpful in terms of more efficient plant layout, as well as in measuring the productivity of clients for purposes of salary adjustments.

Professional Training

The ILRP is increasingly used for field work experience in the professional training of social workers and rehabilitation counselors. The field work of social workers has been described in Chapter 6.

Since 1957, when the Rehabilitation Counseling Curriculum was established at San Francisco State College, field work for Rehabilitation Counseling Students was provided in the Work-Training Center[17] and in the ILRP. Supervision was provided by the ILRP Project Director, and by the Coordinator of Training (herself a graduate of the S.F. State College program) in cooperation with the College staff. While no follow-up of all those who received their field work in the W-TC and ILRP has been done, several graduates have gone into programs serving the mentally retarded. In addition, three Master's theses were completed involving W-TC and ILRP enrollees.[18,19,20] ILRP staff members have lectured to the graduate students in the Rehabilitation Counseling Curriculum.

The ILRP has been used as field work by several undergraduate students in Special Education, majoring in education of the mentally retarded. During the Summer of 1964, a public school teacher of the mentally retarded served as a volunteer to gain experience in developing a program in her school system for older "trainable" mentally retarded students.

Almost every day professional workers and interested non-professionals visit the program. The staff describes the program and answers their questions. Letters and informal contacts with some of the visitors have indicated that their observation of the program has had an impact on their attitudes. Several have requested assistance in establishing a similar program in their local community.

Volunteers

The role of volunteers in the ILRP has several aspects. First it is important that they be selected on the basis of interest, training and consistency. Volunteers come from several sources, including the S.F. Volunteer Bureau, but mainly on the basis of self-referral. When the volunteer presents himself, a screening interview is arranged with the Volunteer Coordinator, who has been the Chief of Social Services. At this time information about the volunteer is obtained, and a decision reached as to whether to accept or reject the offer of volunteer services. Not all are accepted, since some present obvious personality defects, while others are unwilling or unable to meet the program demands. Wherever possible, volunteers who are not accepted are referred to other programs in which they show interest.

Second, it is essential to establish the nature of the relationship between volunteer and ILRP staff members. Except for the VISTA Staff (see below), each volunteer is assigned to a staff member to assist in whatever way the staff member can use help. The staff member defines the sphere of activity and responsibility and provides the necessary training and supervision. This is especially important when volunteers work directly with enrollees as in the training program. It is essential that enrollees recognize that the volunteer is the assistant to and representative of the staff member, but is not a full-time staff member with whom a long-term, on-going relationship is established, otherwise they become confused in terms of volunteer-staff roles.

Third, volunteers are representatives of the community in direct contact with members of the public who have little knowledge or appreciation of the program. As such, the volunteers communicate to ever-widening circles of family, friends, and acquaintances, the philosophy and methods of the ILRP. Such volunteers stimulate others to volunteer their services and to contribute support not only to this program, but to other programs for the handicapped.

Fourth, the use of volunteers in a program like the ILRP has wider ramifications than are immediately apparent. There is a growing reservoir of manpower among those who have retired, those with irregular working hours such as airline stewardesses, housewives who have completed raising their families, and young people in high school and college. This constitutes an important resource for volunteer work which is largely untapped, and might be developed under the tutelage of a trained volunteer coordinator.

In the Spring of 1965, ten VISTA (Volunteers in Service to America) volunteers under the terms of the Federal Anti-Poverty Legislation (U.S. Economic Opportunity Act of 1964) were assigned to SFARC. Two VISTA staff were assigned full-time to the ILRP. These two serve in a different way from the part-time volunteers referred to above.

The VISTA staff is assigned to provide enriched training and counseling services under ILRP Staff supervision. Unlike part-time volunteers, however, the VISTA Staff, like ILRP regular staff, have access to all confidential files on enrollees and attend all ILRP Staff meetings, case reviews and psychiatric consultations. They engage in training individual enrollees in reading, writing, arithmetic, travel training, money management, under supervision of the Training Coordinator, provide casework services under supervision of the Chief of Social Service, and serve in special assignments as the need arises. Over-all supervision of their activities is the responsibility of the Project Director.

Experience with the VISTA staff to date has been most gratifying. They are hard-working, conscientious, dedicated young men and women, who have been giving of themselves not only during the day but in evening and week-end programs as well.

CHAPTER 8

COMMUNITY ORGANIZATION AS RELATED TO ILRP

(This chapter was prepared by Mrs. Margarete Connolly, A.B., Executive Director, San Francisco Aid Retarded Children, Inc.)

Community organization is a method of helping a community to recognize a community problem and to find a way to solve this problem. Mental retardation is a community problem too long forgotten. It is the aim of this project, beyond that of demonstrating a service, to create a community recognition of the needs of the mentally retarded.

Community organization is the planned process of effecting community change---presumably for the better!

By implication, every demonstration project carries with it responsibilities for community organization. Further, the primary role of San Francisco Aid Retarded Children (SFARC) has been defined as a community organization role on behalf of persons--of all ages-- with mental retardation and on behalf of their families.

Today this process takes place in a society which is faster moving, more complex, more demanding than any in history. The objectives (see also Chapter 1) of the community organization efforts around ILRP are to:

1. Interpret to the appropriate lay and professional persons and groups how the unique program design meets the needs of a particular group of young people with a serious handicap.

2. Promote a change in lay and professional attitudes about the ability of the mentally retarded to respond to and use services offered.

3. Establish a permanent ongoing program for home consumption: that is, within San Francisco. This assumes sound financial support.

4. Define the principles on which the program is based so that those principles could be promulgated and adapted for other communities in Region IX (as was the charge by VRA), in the United States or in the world.

5. Demonstrate the role of ILRP in a total scheme of planning for the adult with mental retardation.

6. Pick up the implications of the demonstration which relate to other community programs and involving other agencies, use these implications in long-range planning: i.e. many clients who completed the program of ILRP showed a need for sheltered employment, hence pointing up the gaps in this kind of service in San Francisco; other clients showed signs of deprivation from lack of social experience with peers and hence was underscored the need for recreational opportunities. This implies offering consultation to community agencies which serve the mentally retarded.

7. Feed the findings of ILRP to the Public Affairs Committees of the California Council for Retarded Children, National Association for Retarded Children and organizations of similar purpose, in order to document legislative planning.

8. Participate as broadly as time allowed in professional education programs of the colleges and universities of the San Francisco Bay Area in order to pass along the philosophy and techniques of ILRP, and of SFARC.

The community organization design of a project such as ILRP presumes a commitment to certain goals (in this case, organized services to adult mentally retarded) on the part of SFARC, which:

1. Existed before launching of the project.

2. Held fast during the life of the project.

3. Continue after the project has been institutionalized as an ongoing program.

The presumption also exists that the process of change will be effected by the joint efforts of organization membership, Board of Trustees, clients and staff in an orderly and deliberate process. Self evaluation is continuous, but success or failure is most clearly evident in an answer to the question: Is the service, which the project sought to develop, on-going now? Have communities other than the original home community picked up the gauntlet? Or negatively, have the findings stated that the premise on which the project was launched has proven to be ineffectual?

Wilbur Cohen has said: "The Great Society will not be achieved by one measure, or in one year. It can be produced only as a giant mosaic, thoughtfully, and sometimes painfully put together by many people over a period of time."[21]

The process by which ILRP emerged out of the process of planned community change for the benefit of certain people with mental retardation, stated in a greatly simplified manner, went something like this:

1. A planning project (1956-1957) in San Francisco for services to adults with mental retardation; these services related to work and had vocational meaning;

2. emerging from the planning a demonstration of a Work-Training Center for Retarded Adults (VRA R-D 205, 1957-1961);[22]

3. after the Work-Training Center project was completed, it was picked up as a service by the State Department of Rehabilitation and finally integrated into a workshop serving persons with multiple handicap conditions (San Francisco Community Rehabilitation Workshop);

4. the failures with certain clients, as well as the gaps in the expanse of service of the Work-Training Center were identified, and

5. the Independent Living Rehabilitation Program design emerged.

As an aside, I would like to point out that it was the consistent support which the members of SFARC received from VRA and the State Department of Rehabilitation over a period of years both in financing and in professional consultative services which probably, more than anything else, contributed to the orderly development of services to the adult retarded which is ongoing in San Francisco and in the State of California.

The ILRP is an approach to services to severely mentally retarded adults which combines the techniques, in part or full, of many other programs: the work adjustment shop, the sheltered employment shop, group social work services, casework, the therapeutic community. Bringing the community organization process to bear has been an engineering problem.

The community organization process begins with getting "the show on the road" and that involves the developing of a professional program design, obtaining the blessing of the sponsoring organization, and of concerned professional groups such as the National Rehabilitation Association, Council of Social Planning, etc., getting funds to support the demonstration period, assessing the strength of support for a permanent program and finding the funds to underwrite that support. The activities which precede the actual launching of the demonstration may be as important as any subsequent activities.

In specific language, a project implies that a professional program design has been achieved and endorsed by the professional community; the Board of Trustees and appropriate related committees understand the purpose of the project and are sold on taking it on; and those amorphous groups in the community which comprise the power structure and which are in a position to lend financial, service and political support are ready to commit local matching support.

In the case of ILRP it was obvious through conversation and planning with the Regional Office of VRA that the Federal agency was interested in this approach to a rehabilitation program for those mentally retarded adults who previously had been thought not to be "feasible". Matching funds for a Federal grant implies that one has sold this program and its concept to the membership of the sponsoring agency and to the power structure of the community which will underwrite these costs. During the demonstration period, the process begins with reporting to the Region, in which the project is an innovation, on the program design, the progress of events and eventually the implications of that design for communities, large and small, in that Region. Concurrently, the process is carried on of finding and solidifying permanent sponsorship, if the program is worthwhile. We are presuming, of course, that we are talking about a well-designed, well-mounted program so that there is no doubt about the integrity of the demonstration. In essence, this is the community organization process.

Since by SFARC policy, some part of the community organization process is the responsibility of every SFARC member, staff member and perhaps the client, too, this process around ILRP was a natural one. Or to state this in another way: community organization is planned, purposeful and specific, but like the iceberg, the largest part is below the surface: everyone involved directly or indirectly in a demonstration project is also involved in the community organization process.

Some of the essential ingredients to which we are committed:

1. Those ingredients mentioned earlier: a well-documented and supported idea and program design. Part of the process is a program which stands up under scrutiny, and carries conviction on the part of staff.

2. A clear, articulated purpose agreed upon internally within the sponsoring agency, out of which sound job descriptions emerge for staff. The worker may improvise on occasion, trade roles temporarily with another worker, but he does this from an agreed base.

3. It is not enough to do a good job in the program, it is essential to convey information which makes this a good job to key people.

It becomes obvious, therefore, that the community organization process goes on on many levels, with varied tempos, with varied emphasis--much as a symphony develops under the hands of the composer, the orchestra leader and the musicians. Sometimes it's hard to tell who has created which part of the final effect, and the notes of the conductor, chairman of the board, impresario and concert master are interrelated and interdependent. Community organization is planned, purposeful and specific, but control of specific facets rotates from hand to hand.

Mme. Ghandi of India has said "This is the age of interdependence". Nowhere is this clearer today than in direct services to people. The demands of professional specialization today as more and greater knowledge becomes available in vocational counseling, placement, employment opportunities, social work, psychiatric counseling, etc. and the shifting labor market, the ever increasing social demands on people today all combine to require new and creative approaches to helping people in trouble.

Specialization also brings with it the need to underscore good communication between client and services, good coordination of services, greater responsibility on the part of both the client and the professional worker.

To attempt to evaluate cause and effect without a formal research base is a dangerous practice, since the complexity and multi-faceted aspects of developing a program and attempting to institutionalize it elude easy assessment; unfortunately, we are not prepared to research our community organization practices.

Under the principles earlier stated, a rough assessment of these practices as related to the community organization objectives outlined, goes something like this:

1. The first objective (interpretation to appropriate lay and professional groups) was approached in myriad ways: talks to service clubs and professional meetings; visits by professional groups, students and community leaders, service on local, state and national boards and committees; participation on planning institutes and councils; and most important, word of mouth interpretation by client families. These activities were carried out by SFARC members, LARC auxiliary, staff and some volunteers who did not become formally affiliated.

2. The objective of establishing ILRP as a service program has been achieved on a limited and not very satisfactory basis, at this writing.

3. This present report is one of many reports, papers* and thoughtful replies to inquiries which staff members produced in four years.

4. The objective of developing a total program design for the adult retarded has been achieved clearly in the San Francisco Community, less clearly in California in general. Simply stated, we now offer the adult with mental retardation these resources (although all are selective and hence

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* 23,24,25,26,27,28,29,30,31,32,33,34,35,36,37,38.

exclude certain individuals either due to legal limitations or lack of funds):

a. DR: an integrated training and rehabilitation program for the clearly "vocationally feasible" person. Cooperative programs with other agencies such as Mental Hygiene, Social Welfare, etc. are either operant or in the planning stage.

b. SFCRW: an integrated workshop offering vocational training and for a few, extended work experience. Funded by DR for vocational training and by SFARC for extended work experience.

c. ILRP: a short-term, intensive evaluation, training, and social service program of a vocational preparation nature for seriously handicapped persons.

d. SFARC Adult Training Center: a long-term sheltered employment and socially educational program for seriously handicapped retarded adults.

e. In addition, there are a few programs wuch as Goodwill Industries and Disabled Employees Rehabilitation Workshop which offer long-term work experience and sheltered employment.

4. We are fortunate in San Francisco in having in operation, as a parallel program to that of SFARC, the VRA project of the San Francisco Coordinating Council on Mental Retardation. This is a community organization project aimed at establishing a continuum of services for the mentally retarded in San Francisco. We have had the opportunity to feed into the project both the positive and the negative findings of ILRP for the purposes of action.

5. While the fruit of the experience in ILRP have been given, in conceptual form, to those bodies which influence legislative action, this has not been accomplished as fully as we had hoped. An important achievement has been conveying, through SFARC, the implications of our findings to the Governor's Mental Retardation Program and Standards Board. It is evident that this kind of communication must, through the ongoing ILRP, be a long-term responsibility.

6. Professional education has moved forward on three levels (see also Chapter 7). First, there are formal field work placements from the institutions of higher learning, most notable that of the University of California School of Social Work which has assigned a half-time

> faculty member to supervise professional experience in ILRP. Second, volunteers, staff and VISTA staff in the program have been influenced by their experience to the extent of going on for further study in the field of mental retardation. Third, staff members have been asked to teach evening and summer courses or give periodic lectures in various classes such as those in special education, vocational rehabilitation counseling, workshop directors training, social work, medicine, nursing, etc.

In general, one large question relates to whether or not we have been able to convey our convictions to communities beyond San Francisco; a rough assessment suggests we have not. SFARC feels a commitment to continue this process of communicating findings.

The other general question which remains unanswered is the relationship of ILRP to the SFCRW. It had been an unarticulated goal to incorporate ILRP as an integral part of SFCRW. It is generally conceded that SFCRW is still in the developmental stage and not stabilized to the extent that dialogue could be initiated to examine this questions. It is hoped that as the project phase of ILRP terminates, the ability of SFCRW to entertain the idea of a merger would be evident. The timing, however, is too tight. SFCRW is not yet ready to consider such a merger. This is a question for which an answer must still be sought.

Whither Goes ILRP?

At this writing, the future of ILRP is not clear. In the four years of the project, the total amount of funds expended was about $240,000; approximately 50% of this was VRA funds and the State agency was required to O.K. the project: both program and budget. Despite this concerned approval and many further concrete indications of support, the California State Department of Rehabilitation has not been sold on the basic theme of the project.

We had recognized, in the earlier Work-Training Center project, that the failure with some clients related to estrangement of parents and foster parents from the day-to-day goals of the project; hence in ILRP we involve families in a group work program which aims at helping families to reinforce the training which takes place in the program (see Chapters 4 and 6).

The group work process implies the use of social workers in many aspects of the program, and we developed a strong social work program. In fact, we are the only facility serving the mentally retarded in the Bay Area which is used for field work placement of social work students of the University of California (see also Chapter 6).

The literature is replete with reports from placement specialists, employers, and vocational workers to the effect that the mentally retarded client fails most often on the job because of inappropriate personal behavior or inappropriate interference by families. Currently, the California Department of Rehabilitation proposes to support only the workshop phase of ILRP. It is our belief, however, that support must include use of the social work approach to involvement of clients and their families in order to speed-up and solidify the vocational achievements of seriously handicapped m.r. young adults.

DR is providing intake, pre-evaluation and some follow-up.

What are the convictions of the Department about involvement of families in the process if DR does not allow for fiscal support of this phase of the program?

ILRP is presently operating on a minimum subsistence level by using, in addition to DR workshop fees, adult educators from the San Francisco School Department; psychiatric services from the Community Mental Health Services of the San Francisco Health Department; administrative funds from SFARC, an agency of the United Bay Area Crusade; and fees from parents (see also Chapter 9).

Perhaps this is an ideal combination of support, if it can be adequately enriched; but we believe it is important that sources of support be identified (see also, Chapter 9).

The question of who "rehabilitates" the client, since this item becomes a statistical number, which finds its way to the Congress, the State Legislature and the local Board of Supervisors, among others, is meaningful.

Perhaps the fault, if fault there be, in the planning is the result of an over-enthusiasm for the potentials of Public Law 89-333 with its 18 month evaluation and training period allowed for mentally retarded clients who might otherwise be felt to be non-feasible.

As far as San Francisco proper is concerned, we might well develop a satisfactory fiscal structure on which to operate the program; the dilemma is in our feeling of responsibility to introduce this program, which we know is effective, to the State of California and Region IX. In this instance, we feel that a major support appropriately comes from the Department of Rehabilitation. Either the Department can use this program or cannot use it. Until we determine the Departmental position, we have not met our charge.

If, as some feel, the program is more social rehabilitation than pre-vocational, should another agency such as Mental Hygiene or Social Welfare be the appropriate sponsor, or should some way be found to bring about joint sponsorship based on the client's needs?

In any event, the future of San Francisco's ILRP is presently being debated in the Rehabilitation Section of the Council of Social Planning, in the local chapter of NRA, in the Coordinating Council on Mental Retardation and over the coffee cups where concerned people gather together. As the pieces fall into place, the mosaic will become clear.

The alternatives at the moment seem to be:

1. Meet what seem to be the urgent and current needs of some clients and of DR by redesigning the program without family involvement, as solely an evaluation program;

2. Work out a contractual arrangement whereby certain phases of the program are paid by different agencies: a cooperative agreement; or

3. Redesign the program as a social rehabilitation program funded by agencies such as Social Welfare and Mental Hygiene.

It has been an exciting and fruitful four years. Changes in community attitudes have been evident, even though it is not possible to show direct cause and effect. There is movement in the entire community, lay and professional, which is positive for the benefit of those persons with mental retardation and their families.

We feel that we have clearly met the objectives listed earlier, with the one important exception: whither goes ILRP?

CHAPTER 9

STAFFING, FINANCING, PHYSICAL FACILITIES USED

Staffing

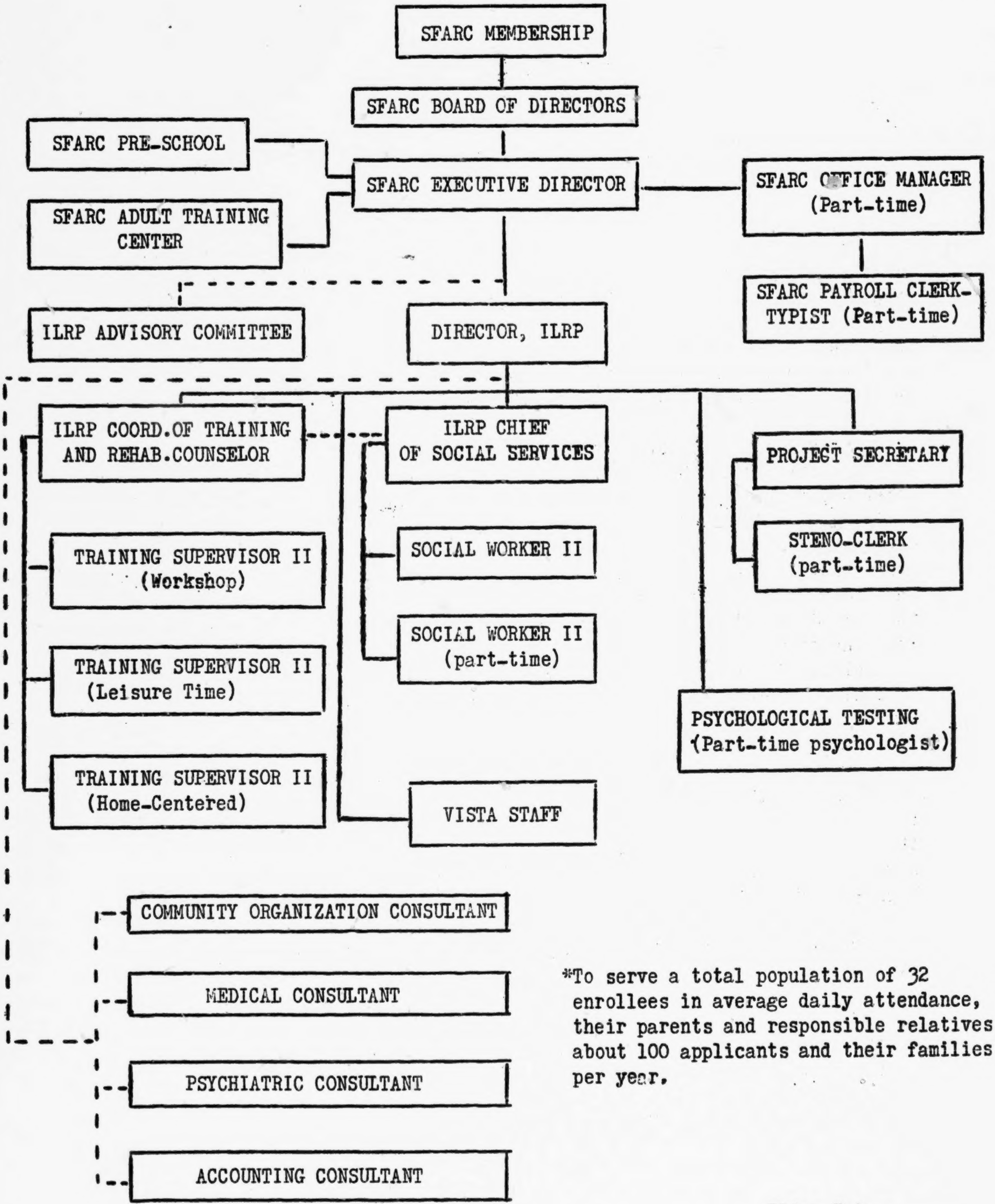
Chart 2 presents the table of organization of the ILRP, showing administrative relationships. The ILRP is a project of SFARC. The ILRP Project Director is responsible to the SFARC Executive Director, in turn responsible to the SFARC Board of Directors, who are elected by the SFARC membership. The program is designed to serve a total population of 32 enrollees in average daily attendance, their parents and relatives, and about 100 applicants and their families per year.

The Project Director is responsible for over-all ILRP policy decisions in cooperation with the SFARC Executive Director, for budget preparation and other administrative assignments. He directly supervises the Coordinator of Training, the Chief of Social Services, and the ILRP Office Staff. The Coordinator of Training supervises the various aspects of the Training Program, including the assignments of the VISTA staff to the Training Program. One Training Supervisor is assigned to the Leisure Time Activities, one to the Home-Centered Activities and one to the Workshop. The Coordinator of Training coordinates the workshop program, and provides rehabilitation counselling for those who are moving towards vocational placement. The Chief of Social Services supervises one full-time and one half-time Social Worker, carries a small case load of enrollees and families, engages in group work services, screens and assigns volunteers and supervises counselling activities of the VISTA staff. Each Social Worker carries a case load of 14-16 enrollees and their families, does group work and family counselling. The ILRP Secretary, in addition to her regular duties, supervises a half-time stenographer-clerk, provides information, and serves as a communication link between staff members, and between ILRP and the SFARC Central Office. Psychological testing is purchased as needed from a clinical psychologist.

Consultants are available to the whole staff, or to individual members as needed.

The above is intended to convey only the formal relationships among staff members and the relationship between ILRP and SFARC. However, to conduct such a program, clarification of responsibilities and assignments

CHART 2. ORGANIZATION CHART OF ILRP*


SFARC MEMBERSHIP
SFARC BOARD OF DIRECTORS
SFARC PRE-SCHOOL
SFARC EXECUTIVE DIRECTOR
SFARC OFFICE MANAGER (Part-time)
SFARC ADULT TRAINING CENTER
SFARC PAYROLL CLERK-TYPIST (Part-time)
ILRP ADVISORY COMMITTEE
DIRECTOR, ILRP
ILRP COORD. OF TRAINING AND REHAB. COUNSELOR
ILRP CHIEF OF SOCIAL SERVICES
PROJECT SECRETARY
TRAINING SUPERVISOR II (Workshop)
SOCIAL WORKER II
STENO-CLERK (part-time)
SOCIAL WORKER II (part-time)
TRAINING SUPERVISOR II (Leisure Time)
PSYCHOLOGICAL TESTING (Part-time psychologist)
TRAINING SUPERVISOR II (Home-Centered)
VISTA STAFF
COMMUNITY ORGANIZATION CONSULTANT
MEDICAL CONSULTANT
PSYCHIATRIC CONSULTANT
ACCOUNTING CONSULTANT

*To serve a total population of 32 enrollees in average daily attendance, their parents and responsible relatives, about 100 applicants and their families per year.

Elias Katz
October 1965

EK:pw

assumes great importance. By good fortune, there was no change during the project period in the SFARC Executive Director, ILRP Project Director, Coordinator of Training, Chief of Social Services, and Project Secretary. Most of the members of this "team" had been working together for several years prior to the start of the ILRP. The "team" functioning in this manner breeds confidence in the program, provides mutual reinforcement in times of crisis, and facilitates communication among all staff members. There was relatively little turnover in staff during the four years of the project, and with few exceptions, those who left the program did so for personal reasons at times of crisis in the financial future of the program or the agency.

Costs of the Program

The major costs of the program are salaries of staff and overhead expenses. An additional cost is the enrollee payroll.

Staff Salaries

Every effort has been made to recruit trained and experienced professional staff. This means competing with other agencies (such as State Civil Service and private agencies) which offer not only comparable salaries, but permanency, pensions, health insurance, etc., which are not available in a project of this type. The fact that key staff members have remained throughout the project indicates that the program provides not only appropriate salaries at the professional level, but personal and professional satisfactions which are of value to the staff members.

Overhead Expenses

Operating costs include such items as rent, utilities, purchase of equipment and supplies, telephone, travel expenses, and other necessary expenditures. Rent covers space requirements for offices, work areas, lounge, storage, etc.

Enrollee Payroll

Salaries for enrollees are based on productivity on contract work. Also included are salaries while in messenger training, and janitorial training. Enrollees are not paid when they are assigned to Home-Centered activities and Leisure Time activities. The cost of the trainee payroll is covered by the income from contract work.

Sources of Income during the Project Period (1961-1965)

The broad categories of financial support for the ILRP are the Federal grant from U.S. Vocational Rehabilitation Administration, funds provided by the grantee agency (SFARC) and "third party" contributions of funds and staff.

The Vocational Rehabilitation Administration Grant

During the project period the annual Federal grant has been decreasing as matching funds are being provided by the grantee agency. The goal has been to set the stage so that by the end of the project Federal grant funds would no longer be required.

Grantee Agency Funding

Funds from the grantee agency have been obtained primarily from foundations and individual contributors who allocate their funds directly for this purpose.

A small amount has come from monthly fees paid by parents or responsible relatives on the basis of financial ability to pay.

In 1964 for a short period, a fee of $50 per month was paid for a few enrollees under a special program for ATD (Aid to the Disabled) clients of the State Department of Social Welfare administered by the State Department of Rehabilitation.

No precise figure has been set to cover the over-all guidance and administrative support provided by S.F. Aid Retarded Children, but this could well account for at least 10% to 20% of the total budget.

Brief reference should be made to the income from work performed by enrollees. The prevailing practice in sheltered workshops is for the income from work to cover not only the enrollee payroll, but the overhead expenses associated with the gaining of this income. The difference between gross income from work and trainee payroll is sometimes called the "overage" from work. Some workshops have arranged matters so that the enrollee payroll should be equal to the "overage" from contract work (50-50 ratio). In order to achieve such a ratio of enrollee payroll to "overage" it is essential that income from contract work be sufficient to cover the total cost. This is especially important if enrollees are to be paid according to productivity, as required by Federal Wages and Hours Regulations.

So far as the ILRP's enrollees are concerned, income from contract work has usually been less than the enrollee payroll. This is due to the fact that all enrollees are paid a minimum wage of 15¢ per hour, and in many cases their productivity has been below that rate. Furthermore, enrollees have been paid when not working owing to reasons associated with their training or social service interviews. Only a small amount of "overage" has been generated. After the move to 475 Brannan Street, an upsurge in productivity took place, and the "overage" began to increase. The goal is to bring the "overage" to equal the enrollee payroll.

"Third Party Contributions"

"Third Party Contributions" during the project period have come from three sources, Adult Education Staff from the S.F. Unified School District; Community Mental Health Services of the City and County of San Francisco, Department of Public Health; Office of the State Rehabilitation Workshop Consultant. VISTA volunteer staff and social work students might also be included under this category.

Adult Education Staff

Since 1953, the Adult Education Division of the S.F. Unified School District has furnished full-time staff members to train mentally retarded adults in the sheltered workshop operated by the S.F. Aid Retarded Children. This practice was initiated in the SFARC Sheltered Workshop (1953-1957), was continued in the Work-Training Center Project (1957-1961) and has been continued in the ILRP. These instructors are employed and paid by the school district and are assigned to ILRP. The school district provides necessary supplies and administrative costs for these staff members. The school district's funds come from a combination of state funds and S.F. City and County funds.

Psychiatric Consultation

Since 1962, the Community Mental Health Services of the S.F. City and County Department of Public Health has provided a Psychiatric Consultant without cost to ILRP, at first on a once-a-month basis, later on a once-a-week basis. These funds come from a combination of State funds and S.F. City and County funds.

Rehabilitation Workshop Consultation

Since 1961, the Office of the Rehabilitation Workshop Consultant, State Department of Rehabilitation, has provided industrial engineering consultation as requested by the ILRP staff, in the same way such consultation is available on request by other sheltered workshops in California. Technically, this consultation has not been "counted" as a "third party contribution" since Vocational Rehabilitation Administration funds are involved, but it does exist as a cost which would have to be paid if not available from this source.

VISTA volunteers, graduate students in social work and rehabilitation counselling and volunteers might be considered as making "third party" contribution by their respective programs in terms of manpower and service to enrollees. This is difficult to measure, owing to the correlated factors of staff time and energy devoted to their training and supervision.

"Single support" vs. "Multiple support"

The above brief description of financing during the project period indicates that a "multiple support" approach has been used, with a combination of Federal VRA grant, matching funds from the grantee agency and "third party" contributions. The question which has been of concern from the beginning is "what form of financing is possible after the termination of the Federal grant?"

One can postulate two somewhat different approaches to financing, "single support" and "multiple support". Under "single support", the total cost of the program would be assumed by one agency. It should be emphasized that there is a distinction between paying for the cost of the program and operating the program, since it is conceivable that an agency could make a contract with S.F. Aid Retarded Children and pay it to operate the program. What is referred to here is that the total cost of the program would be provided by only one agency, whether public or private, from its own budget.

Under "multiple support" funds might come from a variety of sources, including public and private agencies, third-party contributions, fees from parents, etc.

There are advantages and disadvantages to both approaches. An important advantage to "single support" is the simplification of the financial arrangement. This means clearer understanding of costs and the basis for paying for costs. It means being able to budget more precisely and to plan for the future. Among the disadvantages is the possibility that costs of certain services cannot be legally assumed by the supporting agency, which in effect means that these services cannot be provided. In addition, dealing with only one agency may substantially reduce flexibility in coping with changes in patterns of program, as well as short-term experimentation and exploration. It is also possible that over a period of time changes may develop in agency policy and the commitment of the one funding agency may decline. ("Don't put all your eggs in one basket").

So far as "multiple support" is concerned, one advantage is that funds from several sources may make it possible to establish and to enrich a program which could not otherwise develop. However, disadvantages do exist, in that when several sources contribute funds there may be uncertainty as to the total available income, and it may be hard to plan and budget in the light of so many funding variables.

Physical Facilities

In order to carry out this program, appropriate space, equipment and supplies are required. Following is an estimate of space requirements:

1 - Director's office (12' x 18')	216 sq. ft.
1 - Secretary's office for 2 secretaries, desks, files, etc. (18' x 20')	360 sq. ft.
1 - Storeroom (10' x 10')	100 sq. ft.
1 - Workshop for 16-20 enrollees (20' x 40')	800 sq. ft.
1 - Home Centered Activities Suite (large kitchen, 15' x 20'; bedroom, 12' x 16'; bathroom, 8' x 10')	472 sq. ft.
1 - Leisure Time activities room (20' x 30')	600 sq. ft.
1 - Training Staff Office for 4 staff members (18' x 20')	360 sq. ft.
1 - Chief of Social Services Office (8' x 10')	80 sq. ft.
1 - Social Worker Office (8' x 10')	80 sq. ft.
1 - Social Worker Office (8' x 10')	80 sq. ft.
1 - Student Social Worker Office for 4 students (18' x 20')	360 sq. ft.
1 - Interviewing Room (8' x 10')	80 sq. ft.
1 - Field Work Supervisor Office (8' x 10')	80 sq. ft.
1 - Group Work room (10' x 12')	120 sq. ft.
1 - VISTA Staff office for 2 VISTA staff (10' x 15')	150 sq. ft.
Lounge and Group meeting room (30' x 40')	1200 sq. ft.
4 - Bathrooms (2 for men and 2 for women; 8' x 10')	1320 sq. ft.
1 - Rest Room (8' x 10')	80 sq. ft.
Total	5532 sq. ft.

It should be noted that many of the rooms must be soundproof, in order to maintain confidentiality of the client communications and to permit free expression of feelings without interfering with others. This is also true of the Lounge, a program which must be conducted with freedom to engage in activities which may be noisy.

Up to August 1965, adequate space was available in a building at 1680 Mission Street, which was also occupied by the S.F. Community Rehabilitation Workshop, (successor to the Morrison Rehabilitation Center). After August 1965, when the SFCRW moved to 475 Brannan Street and the ILRP occupied space in the same building, there was no space for a Lounge as previously described, and that program was temporarily discontinued. There was no kitchen facility, and the Home-Centered Activities were limited to making sandwiches for lunch. In addition, serious inconveniences such as absence of soundproof partitions between offices, no central heating system, and the noise of warehouse trucks, dollies, steam pipes, etc., have made for difficulties in being heard in interviews and meetings as well as interference with program activities taking place.

One significant gain with the move to 475 Brannan was the placement of the ILRP Workshop in the same physical area as the SFCRW. At 1680 Mission Street, the ILRP workshop was totally separated from any other workshop. This new arrangement had a visible impact on many enrollees. They were able to observe other handicapped persons working in a business-like manner. They were able to be with others during coffee breaks and lunch periods. They were able to observe workshop procedures which were like those done by normal and less handicapped persons, since the SFCRW includes some workers who are minimally handicapped. There was a noticeable increase in productivity among many enrollees reflected in amount and quality of output per enrollee. This in turn was manifested in improved family attitudes toward certain enrollees.

There is little question that despite high staff morale, poor physical facilities can reduce efficiency, as was demonstrated when the program moved from 1680 Mission Street to 475 Brannan Street in August 1965. Since the new quarters were bare of any office space, the staff went to work building the partitions, moving furniture, and getting the place ready for enrollees. Fortunately, most of the enrollees were at the SFARC Summer Camp during the three weeks immediately following the move to 475 Brannan Street, so they did not lose working time during the renovation. During the months of September and October, the absence of space for the Lounge, and for the Home-Centered Activities meant a weakening of the total ILRP service and a loss in personal, social and pre-vocational experiences which had been found very helpful. As this report is being written, it is clear that if the program is to be conducted adequately, appropriate facilities and equipment must be available.

CHAPTER 10

PROGRAM EVALUATION PROCEDURES

Evaluation of a program such as the ILRP presents many problems, since no valid or reliable measuring instruments exist to perform such an evaluation. Broadly speaking, the program should be evaluated in terms of how well its stated objectives have been achieved. This would call for evaluation of the impact of the program on the retarded adults and their parents who were served, as well as an evaluation of the effects on the broader community rehabilitation services of which it is a part.

Evaluation of Change in Enrollees

So far as evaluating the effects of the program on clients served, this is an area fraught with serious methodological problems. Some of these questions have been expressed by Herzog in her "Guidelines for Evaluative Research".[39] Her reluctant conclusion was that in the present state of evaluative research in the area of psycho-social change of clients, it would be far more profitable to focus on the description of procedures used in bringing about psycho-social change, since the index (or criterion) or psycho-social change is so difficult to define and to measure objectively. She states that the judgment of experts could represent the ultimate criterion as to whether changes had taken place in clients. However, even if expert opinion about client changes were available, there are many questions as to how such opinion could best be expressed, whether in the form of rating scales, informal group consensus, and/or decisions as to future planning for the client.

In the course of the project, the search for indices for evaluating client change yielded several approaches: (a) actual assignments to other agencies on termination from ILRP - "disposition of enrollees on termination"; (b) the ILRP Social Competency Ratings; (c) "global" estimates of "improvement", "no improvement", and "deterioration", independently made by three staff members; (d) other methods of assessing change. These procedures will be briefly described here.

Disposition of Enrollees on Termination from ILRP

One index of the effect of the ILRP is the type of activity in which the enrollee engaged after leaving the program. In the broad sense this can be considered a pragmatic* basis for evaluating the impact of the program on enrollees. This is called "Disposition on Termination from ILRP", since it is possible to know where each enrollee was assigned immediately after being terminated. Actual disposition on termination is different from staff consensus as to the most desirable disposition on termination, for several reasons. This is due to such factors as long waiting periods for entry to other programs during which enrollees do something else, or deteriorate at home, family moving away from San Francisco, the emergence of new programs which are more appropriate than previous staff referrals, and parent or enrollee decisions for enrollee to engage in activities contrary to staff recomendations (such as accepting employment in a difficult job situation).

The various categories of "Disposition on termination from ILRP" are:

(1) Full-time employment on job.
(2) Part-time employment on job.
(3) On-the-job training as assistant in convalescent home.
(4) Employment in sheltered workshop (SFCRW, Goodwill Industries).
(5) SFARC Adult Training Center, primarily activities, socialization, with part-time sheltered workshop.
(6) Placed in State Hospital for the mentally ill.
(7) Placed in State Hospital for the mentally retarded.
(8) Withdrawn by parents, or withdrew from program.
(9) Moved from community.

The above categories of "Dispositions on Termination from ILRP" bear an interesting relationship to DiMichael's[40] classification of the retarded for vocational rehabilitation purposes. Category (1) may be considered as his group of "competitively employable, in competitive employment"; categories (2) and (3) may be considered similar to his group of "marginal competitively employable in transitional workshop employment"; category (4) to his group of "sheltered employable in long term sheltered employment"; and category (5) to his group of "marginal sheltered employable in activity centers". DiMichael has proposed different training and rehabilitation programs for each group, according to their needs.

One could assume that on admission to the ILRP, each new enrollee could be categorized as "marginal sheltered employable in activity centers" in DiMichael's classification, or as "non-vocationally feasible for rehabilitation service" using the phraseology of the State Department of Rehabilitation. Any shift of the enrollee to a category characterized as "sheltered employable", as "marginally competitively employable", or as "competitively employable", (as reflected in the type of program to which the enrollee was actually assigned on termination from ILRP) thus becomes an index of client change to higher levels after attending the ILRP.

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*Pragmatic in the sense that "the test of everything depends on results" - Webster's Dictionary

The ILRP Social Competency Ratings

The ILRP Social Competency Ratings is a rating scale developed by the Project Director in cooperation with the ILRP staff. It is an adaptation of the San Francisco Social Competency Scale[41] by extending items to include the adult mentally retarded, and developing new items more appropriate to the program content of the ILRP. Each item is set up with 3 to 7 alternatives arranged roughly in order of difficulty of performance. Ratings are made at regular case reviews, which take place at the end of the Initial Evaluation Period and again several months (usually about 6 months) later.

The first version of the ILRP Social Competency Ratings contained 84 items, covering the areas of "Homemaking", "Grooming", "Communication", "Travel", "Relationships to the Public", "Personal Development", and "Academic Achievement", 84 separate items in all. This was used 1962-1963.[42] A Revised ILRP Social Competency Ratings was used in 1964-1965. (See Appendix C for a copy of this form). This included a total of 38 items covering ratings in general areas, such as attendance, grooming, self-image, and ratings in the specific areas of service to enrollees, including workshop, leisure-time activities, home-centered activities, academic training and social services.

It should be emphasized that the use of the ILRP Social Competency Ratings of enrollees by Staff is primarily a clinical evaluation experimental procedure, rather than the use of a standardized instrument for measuring psycho-social changes in enrollees while attending the program. It is possible that further refinement and standardization of this procedure might make it more widely useful in other similar programs.

"Global" Estimates of "Improvement" of Enrollees

In September and October, 1965, three ILRP staff members were asked to give their "global impression" of the "Degree of Improvement" of 52 ILRP enrollees who had been terminated since the start of the program, on a five-point scale as follows:

"Deterioration" - "No Improvement" - "Slight Improvement" - "Moderate Improvement" - "Great "Improvement"

Each staff member rated enrollees independently.

One of the raters was a Social Worker who had been employed by ILRP on a part-time basis intermittently during the project and was not familiar with the enrollee population. She was asked to read each case record carefully, and to base her "global impression" solely on case material in the record.

The second was the ILRP Coordinator of Training (and Rehabilitation Counselor), a trained rehabilitation counselor and former teacher, who had held this position throughout the project period and knew all enrollees. (She had also been a staff member during the Work-Training Center Project, 1957-1961).

The third was the Chief of Social Services, a trained social worker and member of the faculty of the School of Social Welfare, University of California, who had been a full-time staff member of the ILRP from the start of the project, and knew all enrollees.

Other Procedures for Evaluating Client Change

A considerable amount of narrative reporting on each enrollee is generated in terms of Staff Reports for Case Reviews, individual social case work and group work reporting of interviews with enrollees and their parents, by staff members, by students, reports of Psychatric Consultations. Much of this material is placed in the permanent Case Record of each enrollee. Relatively little of such reporting could be transformed into quantitative terms which would make it amenable to statistical analysis and for comparison between enrollees, or for assessing "before" and "after" for the enrollee himself. Nevertheless, the availability of such material provided some basis for making judgments as to the degree of change taking place in some enrollees.

Early in the project, an attempt was made to use the Thurston Sentence Completion Test[43] with a view to adapting it for use in the ILRP as a means of evaluating changes noted by the enrollee's parents. In view of some of the methodological problems involved, this project was not carried through to completion, but the preliminary findings are reported in Chapter 12.

Also early in the project, an attempt was made to use the ILRP Social Competency Ratings asking parents of enrollees to rate their child while enrolled in the program. Again, methodological problems, especially the increasing number of enrollees who were not living with their parents but in family care homes, made this procedure too difficult to pursue. The preliminary findings are reported in Chapter 12.

An important index of change in enrollees is the quantity and quality of work done in the Workshop. At periodic intervals time studies of enrollee productivity on contract work are conducted, since such information is required in order to set wages for enrollees in conformance with the regulations of the U.S. Department of Labor, Wages and Hours Division, and in order to determine bids to be made on contracts. A limited study on the productivity of a small number of ILRP enrollees was conducted in 1962, and is reported in Chapter 12.

Evaluation of the Effects of ILRP in addition to Evaluation of Change in Enrollees.

From the statement of project objectives (see Chapter 1) it is apparent that in addition to the demonstration of direct services to m.r. enrollees and their families, the ILRP attempts to achieve other goals.

For example, ILRP objectives are to demonstrate that (1) the ILRP not only can provide a transition for the m.r. adult from the state hospital to community living, but (2) may serve to provide an appropriate alternative to commitment to a state hospital. To evaluate how well goal (1) is achieved, it would be necessary to count the number of ILRP enrollees who were formerly patients in a state hospital for the retarded and who have been able to make a good community adjustment after leaving the state hospital while attending the ILRP. This information is readily available and is reported in Chapter 11.

With respect to goal (2) it would be extremely difficult to count the number of persons who attended the ILRP, who were eligible for admission to a State Hospital and who subsequently were not committed. The very existence of the ILRP significantly changed the orientation of San Francisco authorities responsible for commitment of adult retardates to the State Hospital for the retarded, as well as of the parents and guardians of seriously handicapped retarded adults in San Francisco. The possibility of eventual admission to the ILRP served as a positive deterrent from the community viewpoint, and encouraged the state hospital authorities to restrict their intake of otherwise eligible retarded adults because of the availability of such a community program. Precise evaluation of the effects of this aspect of the program is impossible.

Another goal of the ILRP is to cooperate with the State Department of Rehabilitation in referral, and in total planning for enrollees. Evaluation of program effectiveness in carrying out this goal would be based primarily on assessment of relationships between DR and ILRP on the staff operating level as well as on policy levels, an assessment which is very difficult to make.

Another ILRP goal is to provide field work experiences to graduate and undergraduate students in rehabilitation and related fields. Some evaluation of the effectiveness in this area can be obtained through determining the number of cooperating institutions of higher learning, or other agencies, which have used ILRP as a regular (or occasional) field work experience, and the number of students served. Later follow-up would determine the number of graduate students employed in assignments to which their experience with adult retardates in ILRP had made a contribution. Information relative to training of professional workers has been reported in Chapters 6 and 7.

Perhaps the ultimate evaluation of the effectiveness of the program is whether it survives after the termination of the Federal grant. Survival or discontinuation of the program would have implications not only as to the effectiveness of the service program but to the effectiveness of community organization activities aimed at ongoing community support.

CHAPTER 11

CHARACTERISTICS OF ILRP ENROLLEES

"Characteristics of ILRP enrollees" refers to reportable information about the group of 75 enrollees who were admitted to the program. It does not include information about two enrollees who were admitted, but discontinued after one day. It also does not include information about applicants and their families who were served as part of the Intake procedure and who were not admitted to the program, nor does it include material on the enrollee's family members who also received direct services.

It will be noted that there are gaps in available information about enrollees. These are due to difficulties in data collection, e.g., meager information from referring schools, hospitals, or physicans, as well as to modifications in procedures of data collection as the staff moved into successive levels of greater clarification of project goals and methodology. Information about each enrollee was brought together on the ILRP Enrollee Data Sheet, prior to admission, making it relatively easy to compile the data presented in the Tables in Appendix A. The data was arranged in such a way as to lend itself to statistical treatment on IBM cards, if that should be necessary.

The collection of valid and reliable information on a large number of variables on individual enrollees, often requiring specialized judgment on the part of the recorder remains one of the greatest stumbling blocks to research in rehabilitation.

Referrals to ILRP

Relatively few referral sources accounted for most of the enrollees in the ILRP (Table 1*). More than 50% of the enrollees have been referred by State and County Agencies, only a few by private persons. Many enrollees are known to two or more agencies.

During the early part of the project, eight enrollees were admitted to ILRP from the SFARC Adult Training Center, a long-term program for severely m.r. adults. These enrollees had been clients of the Work-Training Center project[44] and it was felt at the termination of that project that they had not received the intensive evaluation, training and counseling which the ILRP provides and from which they could profit. After being served in the ILRP, four of these enrollees have been placed as long-term clients in the SFCRW and four returned to the SFARC Adult Training Center.

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*Tables 1 through 27 are found in Appendix A.

Chronological Age on Admission

On admission, about half the enrollees were below 20 years of age, more than four-fifths below 26 years, and none older than 35 years (Table 2). This population may be characterized as a "young adult" group. Five enrollees were between 17 and 18 years of age on admission, but this was only because they had come from other cities and were not admitted to a public school program owing to their proximity to 18 years, when schooling is terminated for the m.r. in the San Francisco public schools.

Intelligence Level

Using the AAMD nomenclature,[45] 95% of the enrollees are classified in the "mild", "moderate" and "severe" classification of measured intelligence based on individual intelligence test scores (Table 3).

In terms of the prevailing public school classifications of mentally retarded pupils, about 57% of the enrollees may be classified as "educable mentally retarded" (generally speaking in the I.Q. range 50-75), and 40% as "trainable mentally retarded" (generally speaking in the I.Q. range below 50). The remaining 3% had I.Q. scores above 75.

Social Competency Levels

The AAMD nomenclature provides a preliminary classification procedure for measuring social competency, based on Social Quotient (S.Q.) scores of the Vineland Social Maturity Scale.[46] Owing to such reasons as non-availability of an adult who knew the enrollee well enough to complete the Vineland Social Maturity Scale, it has been possible to obtain S.Q. scores for only 60% of the enrollees (Table 4). Four out of five of those for whom S.Q. scores are available, are classified as Level III "moderate but definite deviation from norms and standards of social competence; capable of self-maintenance in unskilled or semi-skilled occupation; needs supervision and guidance when under mild social or economic stress". This suggests that with appropriate training and counselling some of these enrollees might become partially or totally independent in terms of self-care and self-support.

Academic Achievement Test Scores

For testing academic achievement, the Wide Range Achievement Test[47] has been administered to about two-thirds of the enrollees (Table 5). Many of those for whom no scores are available have been reported by the Psychologist as "not testable" on this test, thus being below 1st Grade level. So far as achieved test scores in Reading, Spelling and Arithmetic, virtually none of those tested have achieved above the 4th Grade level, with the preponderance below the 2nd Grade level. For all practical purposes, most enrollees may be considered functionally illiterate in relation to the general population.

Sex of Enrollees

The ratio of men to women enrollees is about 3 to 2 (Table 6). While this is not an unduly large difference, it does raise questions as to why the program has admitted more men than women. Whether the types of activities are more "masculine", in terms of physical work, whether there was some bias operating in the intake process or whether referral sources tended to refer more men than women remains unclear.

Racial Origin of Enrollees

The racial origin of about 88% of the enrollees has been Caucasian, the remainder being Negroes (Table 7). This percentage of Negroes in the ILRP roughly conforms to the percentage in the population of San Francisco. In view of the small sample no generalizations can be made as to this factor.

Medical Diagnosis of Enrollees (in addition to Mental Retardation)

From a medical diagnostic viewpoint, the "primary" diagnosis for all enrollees is "mental retardation", in varying degrees of severity. In addition to "mental retardation", medical diagnoses and syndromes have been reported for a substantial number of enrollees (Table 8). These diagnoses are in broad categories, such as Down's Syndrome (Mongolism), personality disorders, and neurological conditions associated with sensory impairment. Many have severe verbal communication difficulties. A few enrollees have more than one medical diagnosis. Only seven of the 75 enrollees have no reported medical diagnosis (in addition to "mental retardation".)

It must be emphasized that this information is based on reported medical diagnoses. It is quite possible that some enrollees have medical diagnoses which have not been reported. This high frequency of medical diagnoses among enrollees is consistent with other findings which report a greater incidence of medical diagnoses among the more severely m.r. as compared to the general public.[48]

Estimate of Degree of Physical Handicap

The medical diagnoses do not usually give the degree of severity affecting the general functioning of the person diagnosed. Several procedures are being developed and eveluated to provide such information in the field of rehabilitation among which the most comprehensive is the Rehabilitation Codes.[49] Several years ago the ILRP Project Director developed the "Survey of Degree of Physical Handicap"[50] and has used this procedure in cooperation with the staff and through study of available medical records, to obtain an estimate of the degree of limitation in vision, hearing, speech, arm-hand use, sitting and walking, of enrollees. It must be emphasized that these are subjective evaluations. Tables 9 through 14 present these estimates. The findings are summarized as follows:

Almost none of the enrollees have serious problems with vision, although about 1 in 5 wear glasses.

With the exception of two enrollees who were deaf, none have disabling hearing difficulties.

About 1 in 5 have serious speech problems so far as making themselves understood. Almost two-thirds do not present disabling speech difficulties.

Less than 1 in 10 have problems in arm-hand use, for the most part a function of poor coordination, rather than specific neurological defect such as cerebral palsy.

Almost none of the enrollees have difficulties in sitting up and walking.

The above findings suggest that the most serious physical handicap so far as normal everyday functioning is in the area of speech and verbal communication skills.

Adequacy of Income When Admitted.

The question of "adequacy" of the enrollee's income to meet his needs is an important one, since this makes the difference between having enough financial support to live comfortably as middle-class families do, or to be limited to a survival basis, as do many families on public welfare. A rough estimate of the adequacy of the enrollee's income to meet his needs has been derived from the ability of the family (or the enrollee if no family is available) to pay the stated monthly "fee" of $50.00 per month. The basis on which this fee is determined has been described in Chapter 6, through review and evaluation of family resources during Intake. If the family can afford to pay the full fee, the enrollee income is considered "adequate". If the family or the enrollee is on public assistance, a nominal "fee" of $1.00 per month is charged, and the enrollee's income is considered "inadequate".

It is obvious that this method of determining "adequacy" of enrollee income leaves much to be desired, and a better procedure should be developed to measure this factor.

Socio-Economic Status of Enrollees

A rough indication of the socio-economic status of enrollees is provided by the occupation of the head of the household in which the enrollee resides at the time of admission. Using this crude index, it would appear that about 40% of the enrollees are in the lower socio-economic class, about 35% in the middle class, and about 10% in the upper class, about 15% living in foster homes, whose socio-economic status is variable, but probably could be classified as middle or lower class (Table 16).

Estimates of socio-economic status of enrollees having been derived from such limited information provide only gross trends and must be interpreted cautiously. It would appear that many enrollees live in settings associated with lower socio-economic status rather than higher. If this is true, then it would conform to the widely held beliefs that mental retardation is found more frequently among the lower socio-economic groups. [51]

Major Source of Support When Admitted

None of the enrollees reported earning money for self-support when admitted (Table 17). One-third were reportedly living with families who earned enough to manage to support the enrollee. The remainder were supported by some form of public assistance. For the most part those supported by public assistance received grants from the Aid to the Disabled (ATD) program of the San Francisco City and County Department of Social Services, available for eligible dependent persons over 18 years of age.

Living Arrangements and Family Role Position of Enrollees on Admission

Most of the enrollees were classified as a dependent "son" or "daughter" in their own homes (Table 18). A few were living with relatives and were also in a dependent relationship.

With the exception of 12 enrollees living in family care homes, and one married enrollee, most enrollees live at home with parents or relatives. (Table 18 and 19).

There are great differences in the family structure of those who live at home. In some instances the enrollee lives with one other adult, and in others, he is a member of a sizeable family group including parents and siblings.

In the case of enrollees living in family care homes, the situation is somewhat different. The family caretaker is a surrogate parent. The other patients in the family care home (no more than 6 patients on leave from the state institutions can live in one family care home) must be of the same sex, but may well be of widely differing background and experience, and may even be in conflict with each other and with the family caretaker. There is no assurance that the family care home will be a long-term or permanent one, in contrast to the usual family relationships and living arrangements. "Family care" as a living arrangement for patients on leave from the state hospital has much to offer, in making the transition from institution to community living.

Educational History

More than half of the enrollees had attended public school classes for the trainable mentally retarded (for pupils with I.Q. below 50) during most of their school careers (Table 20). Some had attended classes for the educable mentally retarded (for pupils with I.Q. 50-75), and some had had schooling while patients in a state hospital for the retarded. Four had attended regular school classes. A few reported no schooling, or private schooling, only.

Vocational Rehabilitation Services Prior to Admission

Reportable information on prior vocational rehabilitation services includes evaluation for services by the State Department of Rehabilitation, and prior attendance in a sheltered workshop program (Table 21). About one-fourth of the enrollees had been evaluated by rehabilitation counselors of the State Department of Rehabilitation, and with one exception, had been rejected for service as "non-vocationally feasible". The one exception had been "accepted" by the Department of Rehabilitation, and placed in the S.F. Community Rehabilitation Workshop, but was later referred to the ILRP, as it was felt he could better profit from this program.

Eight enrollees had been enrolled in the SFARC Work-Training Center project and were admitted to the ILRP early in the project period (1962). These had had some evaluation and training. Two had previously been enrolled in the S.F. Community Rehabilitation Workshop (formerly the Morrison Rehabilitation Center Workshop), and had been provided work evaluation and work adjustment.

Five had attended a sheltered workshop in other communities.

These findings indicate that most of those enrolled had been provided with little prior vocational rehabilitation services other than brief screening interviews for possible "vocational feasibility" by the State Department of Rehabilitation, and a few had attended other sheltered workshops prior to admission.

Employment Status Prior to Enrollment

About 80% of the enrollees had no gainful employment prior to admission (Table 22). Of those who had been employed, most had worked in a sheltered workshop providing part-time work under supervision and one or two had had part-time or intermittent employment.

These findings must be interpreted with caution, since it is possible that some enrollees might have had some paid work experience which they did not consider worth reporting, such as homemaking activities, baby sitting etc. The prevailing impression is that by and large these enrollees had not been doing any productive remunerated work prior to enrollment.

Prior History of Hospitalization and/or Psychiatric Care

For about one-half of the enrollees there is no record of prior admission to an institution for the mentally ill or mentally retarded, or of out-patient treatment (Table 23). About one-third of the enrollees have been patients in a state hospital for the mentally retarded, ranging from a relatively short evaluation of several months to a period including most of their lives. Five have been patients in an institution for the mentally ill, and four have been patients receiving outpatient psychiatric treatment.

During the early period of the project, relatively few enrollees were admitted who had recently been in a state hospital for the retarded. Later, more enrollees on leave of absence from the state hospital for the retarded have been admitted.

It is significant to note that about 1 out of 8 enrollees have been sufficiently seriously mentally ill prior to admission to require hospitalization in a mental hospital or out-patient psychiatric treatment. Since serious emotional disturbances have been manifested in a substantial number of enrollees, it is not unreasonable to infer that many with this history would manifest their disturbances while in the ILRP.

The fact that a substantial number of enrollees have been patients in state institutions for the retarded assumes much greater significance when placed in relationship with the project's finding (see below, Chapter 12), that no enrollees were sent to a state hospital for the retarded from ILRP during their stay in the ILRP or immediately following termination.

CHAPTER 12

EFFECTS OF THE ILRP ON ENROLLEES

Disposition on Termination

These findings are based on information as to the disposition on termination from ILRP of 56 enrollees who were admitted after December 1, 1961, and left the program prior to August 1, 1965. At the time of writing this Final Report a number of these former enrollees had been out of the program for some time. In a few instances, it was possible to obtain supplementary information as to their present status, which will be included in the findings.

Thirteen of the 56 terminated enrollees (23%) were "rehabilitated" to the extent of being employed full-time in a sheltered workshop; employed part-time; or placed in an on-the-job training (OJT) as a helper in a nursing home under the auspices of the State Department of Rehabilitation (Table 24). Of these, five had been placed in the SF Community Rehabilitation Workshop providing work experience under supervision. One of these five subsequently was placed full time in a cafeteria as a bus boy. In addition, one enrollee is on the waiting list for admission to the SFCRW. One enrollee is placed as a full-time worker in Goodwill Industries of San Francisco, a sheltered workshop for the handicapped. Three enrollees are working on a part-time basis, largely helping their parents or relatives at home or at their business.

During the later period of the project the DR Rehabilitation Counselor, working closely with the ILRP Coordinator of Training and Rehabilitation Counselor set up an on-the-job training (OJT) program for training ILRP enrollees to become helpers in a nursing home. The DR Rehabilitation Counselor assumed financial and vocational counseling responsibilities, and made arrangements with the employer who provided the on-the-job training. Three female ILRP enrollees were given on-the-job training along these lines. Two enrollees subsequently have been employed in this type of work.

Sixteen enrollees were returned to their parents or relatives on termination from ILRP. These included those whose families moved from San Francisco, and those who were withdrawn by their families. In a few cases withdrawal from the program of the enrollee by the parents was brought about by inability or unwillingness of the parents to participate in social services and counseling provided by the program as agreed upon during Intake.

Twenty-three enrollees were placed in the SFARC Adult Training Center, a long-term program for severely retarded adults providing a minimum of work and much opportunity for socialization and recreation. Of the six enrollees originally referred by SFARC Adult Training Center when the ILRP was started in 1961-1962, two were among the five placed in the SFCRW. This suggests that in some cases the ILRP services help the severely retarded young adult move to a more demanding work setting such as a full-day sheltered workshop.

ILRP Social Competency Ratings (see Appendix C for Sample Form)

Staff Rating and Re-Rating on ILRP Social Competency Ratings

Ratings and re-ratings by staff members on the revised ILRP Social Competency Ratings were available for 40 enrollees during 1964 and 1965. In terms of intelligence test scores these 40 enrollees did not differ significantly from the total group of 75 enrollees. The ratings of these 40 enrollees are reported in Table 25. Owing to the limitations of the data, no Chi-Square test was performed. From inspection of Table 25 it would appear that there are few substantial differences on most items between the rating and re-rating. This lack of substantial differences is found both in comparing frequencies of rating of the same level within each item, and, in the amount of the differences between rating and re-rating on each item. The findings are consistent with the report of a previous study of a group of 17 ILRP enrollees rated and re-rated on an earlier version of the ILRP Social Competency Ratings.

The relatively little change in re-rating of these 40 enrollees in a 6 month period on most of the items throws into relief the few items on which shifts in rating from lower to higher levels are noted. For example, on "Independence from Supervision, etc.", it may be noted that there is a trend upward from a lower to a higher level rating, both as reflected in frequency of rating of each level, as well as in the amount of the difference between rating and re-rating. On "Room Cleaning" there is a slight trend upward from a lower to a higher level. On "Use of Social Case Work" there is a sharper trend upward towards ratings at a higher level.

ILRP Social Competency Ratings of Enrollees Classified as "Higher Vocational Potential" and "Lower Vocational Potential"

Using the information as to disposition on termination from ILRP (Chapter 11) it is possible to classify enrollees as "Higher Vocational Potential" and "Lower Vocational Potential". The "Higher Vocational Potential" group includes 13 enrollees who on termination were placed in the S.F. Community Rehabilitation Workshop, or in Goodwill Industries, employed part-time, and placed in on-the-job training as a helper in a nursing home. The "Lower Vocational Potential" group includes 13 enrollees who were placed in the SFARC Adult Training Center, a program providing socialization and a minimum of work experience, for severely retarded adults.

Inspection of Table 26 indicates that substantially higher ratings were obtained by the 13 "Higher Vocational Potential" enrollees when compared with the 13 "Lower Vocational Potential" enrollees on the following ILRP Social Competency Ratings:

Self-Image
Speed of Work as compared with non-handicapped person doing the same kind of work.
Mastery of Crafts Taught; Carry-over into Leisure Time Activities
Exploration of Interests; Freedom of Expression of ideas and feelings through medium of arts and crafts; self-confidence.
Shopping
Reading
Number concept
Writing
Use of Social Case Work Services in relation to Upsetting Experiences
Group Identification

In view of the small sample, and the many items which did not differentiate between "Higher Vocational Potential" and "Lower Vocational Potential" groups, it is not possible to generalize from these findings. Nevertheless the fact that there was some differentiation between the two groups suggests that it might be worth pursuing the further development and refinement of this rating procedure, with a view to using such methods for better classification of enrollees according to their vocational potential.

Global Estimates of "Improvement" of Enrollees

A common clinical method of evaluating change in patients who have been provided with some form of treatment is for the therapist to make a "global estimate" of whether "improvement" has taken place as a result of the treatment. This is usually a retrospective procedure, and may be reported in checklist form, or in narrative statement. Table 27 reports the findings on global estimates of improvement among 52 enrollees rated by "expert judges", as previously defined in Chapter 10.

From inspection of these estimates the high degree of consistency among the "judges" makes it possible to prepare a "Composite Rating". It should be emphasized that their estimates were made independently, based on retrospective evaluations of enrollees.

In order to facilitate comparison, the ratings arbitrarily have been given values as follows: "Deterioration" = 1; "No Improvement" = 0; "Slight Improvement" = +1; "Moderate Improvement" = +2; "Great Improvement" = +3.

These values are arithmetically combined into a "Composite Rating" ranging from -0.3 to +3.0. The results of this procedure indicate that 4 of the 51 enrollees (8%) were considered to be "Deteriorated" (Composite Rating of -0.3), 7 of the 51 enrollees (14%) were considered to have "Not Improved" (Composite Rating of 0), and the remainder (about 78%) to have "Improved" (Composite Rating of +0.3, +1.3, +1.7, +2.0, +2.3, +2.7, +3.0).

These results strongly suggest that on the basis of independent professional "global" estimates of change in enrollees after they had attended the ILRP there had been a significant improvement in the general functioning of more than 3 out of 4 enrollees.

Other Findings on Client Change

In addition to the findings reported in the immediately preceding section, other information on changes in enrollees has been obtained, and is briefly summarized here:

1. Parent Ratings of their Enrolled Child on the ILRP Social Competency Ratings

In May and June 1962, and again about 8 to 10 months later, a total of 14 ILRP enrollees were rated by their parents on the first version of the ILRP Social Competency Ratings. Parents were asked to rate observed social competency in the home only. Following were the findings of this study:

a. Re-ratings on most items were similar to the original rating. This conforms to the findings as to changes in ratings by the ILRP staff as reported above.

b. In about one-fifth of the returns, there were changes in ratings in the direction of a higher level of competence.

c. Greatest improvements were reported in the areas of "Grooming" "Answering the Door", "Stating Name", and "Traffic Signals".

Owing to several factors, including lack of staff time as well as a shift in population characteristics through admission to ILRP of more enrollees who had recently entered family-care settings, and were not yet known to the family caretaker, it was not possible to continue this interesting study.

2. Changes in Work Productivity of Enrollees

As part of the process of setting wages for enrollees, time studies of work productivity are conducted at periodic intervals. These time studies are based on work performed on contracts, and productivity is compared with that of the non-handicapped worker doing similar work.

In a study (in 1962-1963) of 22 enrollees for whom sequential time studies of work productivity were available, 16 made considerable improvement in the number of items produced per unit of time. Those who started at a higher productive level tended to make greater gains than those who started at a lower level.

Another indication of change in work productivity of enrollees is the amount of time spent in the Workshop. On admission, each enrollee starts with 2 hours in the Workshop, 1 hour in Leisure-Time Activities, 1 hour in Home-Centered Activities. As the enrollee can tolerate a longer work day, this is provided for him. No study of available records as to the increase in work time per client was made owing to the difficulty of pin-pointing such information. The impression of the Training Staff was that about one-half of the enrollees had increased their time in the Workshop from 2 hours to 3 hours daily, and at least one-fifth had increased from 2 hours to 4 hours. When it became clear that an enrollee could work a 4-hour day in the Workshop, the DR Rehabilitation Counselor wes alerted with a view to plan for movement from ILRP to a more demanding placement, such as the SFCRW, on-the-job training, etc.

3. Staff Impressions of Enrollee Change

For the Progress Report to VRA for the period from December 1, 1961 to May 31, 1963, staff members were asked to report their impressions of enrollee change. Following are excerpts from these reports:

"In assessing the 'improvement' in the mentally retarded population of ILRP, the following areas seem significant to me:

Lunch Program: In addition to learning food preparation and simple cooking, the trainees have moved into menu planning, the preparation of menus and inventories, grocery shopping, and the serving of meals they have prepared...
Laundry Service: As a service to the cafeteria and as a training measure for enrollees, we have undertaken to do the laundry for the entire building. The operation of and care for the machines, the sorting, folding and storage of clean laundry, the measuring of soap, bleach and the setting of proper temperatures are all included in the training."- Mrs. Martha Hislop,M.A., Training Coordinator and Rehabilitation Counselor.

"Two kinds of progress can be observed in the workshop. The first is perhaps most obvious; that of general acceptance, adaptation, and application by enrollees in the shop. In the main, they work well on assignments, and time studies show they have improved in proficiency in most cases. However, another kind of observation can be made relative to the differential progress of the enrollees. Perhaps 10, or 1/3, have made considerable progress...Another group has made little progress in workshop skills, but has learned to be in the workshop setting with more equanimity, having better relations with their peers, and understanding more about work...." - Melvin Boyce, B.S., Training Supervisor, Workshop.

"As knowledge of individuals increases with daily contact with the young people, the general atmosphere is a relaxed one with minimal pressure and demands. The young people are encouraged to talk freely, ask for help when necessary, suggest ideas for projects. They are discouraged from saying 'I can't' before they say 'I'll try'...Specifically, there is R-- who can now sit and take instructions rather than feel the need to be constantly on the move; B-- can now say without hesitation that he is willing to fill orders for mosaic pictures, when at first he said 'no'. He is eager to make some extra pocket money by doing extra projects..." - Mrs. Martha Kitajima, OTR, Training Supervisor, Crafts.

"Some enrollees have made more progress than others, and in different directions. Many are quite able to take responsibility, such as making the bed alone. Others need very little supervision...Cleaning and waxing hardwood floors is another one of their experiences. They have learned to use and operate the electric stove and clean it. They can also clean and defrost the refrigerator, scrape, rinse and stack the dishes." -- Mrs. Ethel Ellis, Training Supervisor, Homemaking.

"...Working, keeping house and playing with friends are more than learning skills. These are the ingredients used to strengthen the person and the growth we observe is from the mixture. The social worker helps the enrollee incorporate these ingredients with his past experiences and through the methods he uses with individuals and with groups he helps the individual walk on his own, to the extent he is able...Changes in parental attitudes towards their child are observed through their reporting back to the social worker the new experiences they are having with their child. Their expressions generally indicate their attempts to allow and to encourage their child to do more for himself whether this be to select a personal item for himself, to travel by himself and to meet friends, or to disagree with them...." - Arthur Segal, M.S.W., Chief of Social Service.

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It is hard to generalize about changes of enrollees from these diverse sources of information. However, the general impression derived is that most enrollees have appreciably improved in personal and social areas while enrolled, and that some have been able to move from a state of dependency to a level of considerable productivity and independence.

CHAPTER 13

OTHER FINDINGS OF THE ILRP

Previous chapters have presented findings as to the characteristics of enrollees and the effects of the program on enrollees and their parents who were provided with direct services, based on available documentary material. When one attempts to report on the effects of the program in other areas, it is more difficult to obtain information in usable form. The following findings are based on material from various sources.

1. Continuation of the ILRP after termination of Federal grant support.

Regardless of good intentions of the sponsors of any program, or demonstrated values to clients served, there has always been the question, "How will the project be continued after the grant ends?" This was a problem which became of increasing concern as the project neared the end of its fourth year of Federal grant support.

A major factor making it possible for the ILRP to continue (and for similar programs to be established in the future) was the passage in October 1965 of PL 89-333, the Vocational Rehabilitation Act Amendments of 1965.[52] This legislation provides for allocation of funds to State agencies such as the California State Department of Rehabilitation, to carry on evaluation, training, counseling and rehabilitation for seriously handicapped mentally retarded clients for a period of 18 months. The passage of this legislation alone could not insure the continuation of a program like the ILRP. Through appropriate community organization procedures, the broad involvement of state agencies, local agencies, individuals and organized parent groups, provided a matrix of support for the ILRP immediately following the end of the project on October 31, 1965. Without such a process being operative long before the project's end, there is grave doubt that the ILRP would have been continued. As of November 1, 1965, the State Department of Rehabilitation agreed to purchase rehabilitation services from ILRP, thereby insuring its financial survival. Much remains to be done to clarify the complicated aspects of ongoing financial support for ILRP since there are limitations to the funds available from the Department of Rehabilitation. The fact that the ILRP has been enabled to continue at the same level of service as during the project period constitutes a pragmatic test of the value of the program to the community in which it is operating.

2. The ILRP as a means of providing alternatives to commitment to State Hospital for the Retarded

One of the major thrusts in current programming[53] for seriously handicapped retarded adults is to strengthen community services with two goals in mind: (a) to offer alternative services to the retarded adult other than commitment to a state hospital, and (b) to make it possible for certain retarded adult patients now in state hospitals to leave the hospital and to learn to live in the community. The ILRP is an integral part of the complex of community services for the retarded adult which make possible the achievement of the goals mentioned.

Only fragmentary findings on this score can be presented here. One striking bit of evidence is that, although one-third of the enrollees had been patients in a state hospital for the retarded at some time prior to admission (including many who were on leave and living in family care homes under the supervision of the State Department of Mental Hygiene), not one enrollee was committed or re-committed to the state hospital for the retarded after being terminated from the ILRP.

What this means in terms of human dignity, independence and personal satisfaction cannot be measured. However, the savings in taxpayer's outlays for lifelong hospitalization (estimated at $150,000.00 for the lifetime of one hospitalized retardate at present level of costs) when multiplied even by a few individuals, suggests that those concerned should give careful study to these findings and their implications.

3. The ILRP as a Field Work experience for Students

As described previously, field work experience has been provided for Rehabilitation Counseling Curriculum graduate students of San Francisco State College, undergraduate Social Work Students at S.F. State College and graduate Social Work Students of the School of Social Welfare, University of California, Berkeley Campus, with ILRP staff members giving supervision in cooperation with college and university faculty.

The impact on Social Service students has been pointed out in Chapter 6. Although no systematic follow-up was made of Rehabilitation Counseling Curriculum graduates who had field work in the ILRP it is known that several are now employed as full-time or part-time rehabilitation counselors serving the retarded, one is teaching the retarded, and two are employed intermittently as Work Supervisors in the ILRP. Those who are not now working with the retarded have become highly sensitive to their problems, in their present assignments.

4. Findings as to Gaps in Services for Retarded Adults.

One of the functions of the ILRP is to identify service needs of seriously handicapped retarded adults which are not currently being met in the community. Among these are:

(a) An independent living rehabilitation program for emotionally ill retarded adults. This group could not be served in the ILRP since no psychiatric treatment is available as part of the program, and additional staff and facilities would be needed.

(b) Appropriate social services for family care-takers (foster-parents) in whose homes enrollees on leave from a state hospital live while attending the ILRP. Family care-takers have a relationship with enrollees which is different from that between enrollees and their own parents, and require a different counseling approach which was not provided.

(c) A residential arrangement for enrollees now living in their own homes, who need to live away from home. This could be in the form of a half-way house or foster-care home, an arrangement available only to patients on leave from the state hospital.

(d) Expanded "long-term workshops". Many ILRP enrollees could remain indefinitely in a long-term sheltered workshop on termination from this program. Being placed on the waiting list for the "long-term workshop" of the SFCRW meant waiting months and in some cases years, with the consequent deterioration in gains achieved while in the ILRP.

CHAPTER 14

SUMMARY

The Independent Living Rehabilitation Program is a demonstration project for rehabilitating seriously handicapped mentally retarded young adults by helping them develop to the maximum their potential for achieving higher levels of self-care, self support, and independence in daily living activities.

Objectives

The specific program objectives are:

To evaluate the personal, social and vocational potentials of enrollees;
To provide a program of training and social services for enrollees and their families which will most effectively help them to achieve their maximum potentials;
To help the mentally retarded young adult who leaves school at 18 years of age to make the transition from school to adult society;
To help patients on leave from state hospitals for the mentally retarded make a better adjustment to community living, thereby reducing the number of such patients who must be returned to the institution;
To reduce the present urgent need to commit certain mentally retarded adults to state hospitals by providing a more meaningful alternative to commitment;
To help the enrollee's family to participate actively in the development of his personal, social and vocational competencies, in close cooperation with the ILRP Social Service Staff;
To document and evaluate changes in enrollees and their families as a result of ILRP services;
To cooperate with the State Department of Rehabilitation in making and receiving appropriate referrals to and from that agency, as well as in total planning for enrollee rehabilitation services;
To provide enriched field work experiences for professional training in mental retardation;
To determine the role of the ILRP in a total community organization plan for improved services for the retarded adult in San Francisco, and especially in relation to the San Francisco Community Rehabilitation Workshop;
To develop a plan for long-term financial support of the ILRP;
To communicate ILRP findings to other communities in the Western Region of the United States.

Federal, State and Local Influences

The ILRP was launched December 1961 and terminated as a federally financed project October 31, 1965. Many influences shaped the program design. On the federal level was the interest of the Vocational Rehabilitation Administration in developing services which would make it possible to evaluate, train and counsel those who previously could not be served since their "vocational potential" was so low as to be "not feasible" for vocational rehabilitation services. The ILRP was planned as a demonstration of the values, limitations and problems associated with services for such seriously handicapped individuals.

On the state level, many forces were making their impact as well. The State Department of Rehabilitation had previously demonstrated that more intensive vocational rehabilitation efforts to serve less seriously handicapped mentally retarded adults were productive. The State Department of Social Welfare was shifting towards a rehabilitative approach in relation to public assistance recipients, and was broadening its concepts of Aid to the Disabled (ATD) to serve larger segments of the retarded adult population. The State Department of Education was concerned with the increasing number of retarded young adults leaving public school classes and facing the problems of fitting into the community. The California Study Commission on Mental Retardation addressed itself to an investigation of the problem, and developed legislative proposals for meeting them, many of which were adopted in the California State Legislature in the Spring 1965 session, including the establishment of the statewide Mental Retardation Program and Standards Advisory Board, and the establishment of Regional Diagnostic and Counseling Centers for the Mentally Retarded. (One Regional Center has been established in San Francisco.)

Within San Francisco, many developments have been taking place. Among these was the Demonstration Project of a Work-Training Center, sponsored by S.F. Aid Retarded Children and financed in part by a federal grant from the Vocational Rehabilitation Administration. That project had shown that mildly retarded adults could be vocationally rehabilitated through a sheltered workshop program. Simultaneously there had emerged a strong S.F. Coordinating Council on Mental Retardation which is actively engaged in developing programs and services for the retarded, and is heavily involved in professional training in mental retardation. The S.F. Coordinating Council on Mental Retardation is undertaking the development of a broad comprehensive community action program for serving the retarded. Also joined in developing a broad program of services for the retarded and other handicapped adults in San Francisco are the Rehabilitation Section of the Health Council of the United Bay Area Crusade, and the S. F. Chapter of the National Rehabilitation Association. An important rehabilitation development is the S.F. Community Rehabilitation Workshop (successor to the Morrison Rehabilitation Center Workshop) which now includes several components of the Work-Training Center (1957-1961) including the short-term evaluation service of "vocationally feasible" retarded adults and the long-term sheltered workshop for retarded adults. One of the goals of the ILRP in 1964-1965 has been to explore the possibilities of developing closer working relationships with the S.F. Community Rehabilitation Workshop.

To accomplish the ILRP program goals, a combination of evaluation and work-training of enrollees, and social services with enrollees and their parents is used. This may be characterized as a "therapeutically oriented, interdisciplinary rehabilitation team approach."

Enrollee Characteristics

The 75 ILRP enrollees served during the project period have been referred mostly from State, County and school agencies. By and large, they are "young adults" in chronological age. Most are in the "moderate" and "severe" levels of measured mental retardation (I.Q. below 50), with a few in the "mild" level, (I.Q. above 75). Many are in the "moderate" range of measured social competency (I.Q. 50-75). Most are illiterate. As a group they have a higher than normal incidence of medical diagnoses. Poor verbal communication skills are very common. Most come from lower socio-economic groups, with a few from upper middle class families. Most are eligible for Aid to the Disabled (ATD) public assistance. All live with their families or in family care homes under supervision of the State Department of Mental Hygiene. Most have attended public school classes for the retarded. Few have been provided any vocational rehabilitation services other than brief interviews with a State Department of Rehabilitation Counselor leading to their being classified as "non-vocationally feasible". None have a history of self-support, and only a few of any gainful employment. About one-third have a history of commitment to a State Hospital for the retarded.

Initial Evaluation

After careful evaluation by the Intake Social Worker and the Project Director with staff concurrence as to whether the enrollee might profit from the program, he is admitted for an eight-week evaluation. During the Initial Evaluation Period of eight weeks, the enrollee is observed at work, at play and in social case work interviews and in group work settings. His parents are interviewed by a social worker and involved in the program. At the end of the initial evaluation period, a case review is held with the entire staff to decide whether to continue with the enrollee or to refer him and his family elsewhere. If the enrollee is admitted, he may remain for a maximum of two years, although most enrollees receive maximum benefits from the ILRP and leave in less than two years.

Daily Schedule

The daily schedule includes work-training experiences and social services. Work-training includes at least two hours daily in the Workshop, doing jobs for which the enrollee is paid a minimum wage of 15¢ per hour, with higher salaries based on productivity. In addition he receives training in Leisure Time Activities, in Home-Centered Activities, including home-making and food preparation, in communication skilles, money management and independent travel on public transportation. Those enrollees who show more promise are provided with opportunities to do pre-vocational activities such as janitorial and messenger work, at higher rates of pay.

Social services include individual casework as well as an extensive group work program with enrollees, counselling of groups of enrollees and interviews with the family group including the enrollee. Social Clubs, preparation of a monthly newsletter and recreational activities are conducted as part of the social group work.

Staffing

Administratively the ILRP is a project of S.F. Aid Retarded Children, which provides supportive services and contributes a significant proportion of necessary financial support. The staff includes the Project Director; a Coordinator of Training and Rehabilitation Counselor; three Work Supervisors (one for Workshop, one for Leisure Time Activities; one for Home-Centered Activities); a Chief of Social Services; one Case Worker; one part-time Group Worker; Psychiatric Consultant, Medical Consultant. This staff serves a total population of 32 enrollees in average daily attendance and their families, as well as numerous applications which are screened, and wherever necessary extended interviews provided as part of Intake to the program.

Community Organization

The community organization objectives related to the ILRP are to interpret the program to professional and lay individuals and groups, to gain acceptance for it as a demonstration project, to pick up its implications in long-range planning for gaps in services to ILRP enrollees and their families, and to lay the basis for long-range financial support. Changes brought about by effective community organization are the result of the joint efforts of SFARC membership, Board of Trustees, clients and staff in an orderly and deliberate process. This has been achieved clearly in San Francisco, less clearly in California in general. The Department of Rehabilitation offers training and rehabilitation counseling for the clearly "vocationally feasible" retarded adult. The SFCRW offers vocational training and for a few, extended work experience. The ILRP offers short-term intensive evaluation, training and social services programs of a vocational preparation nature for seriously handicapped adults. The SFARC provides a long term sheltered employment and socially educational program for severely retarded adults. In addition there are a few programs such as Goodwill Industries and Disabled Employees Rehabilitation Workshop offering long-term work experience and sheltered employment for some retarded adults.

As far as San Francisco proper is concerned, a satisfactory fiscal structure can be developed. The question is, how far can the program be introduced elsewhere in California unless the Department of Rehabilitation accepts responsibility for its support. If, as some feel, the program is more social rehabilitation than pre-vocational, should another agency such as Mental Hygiene or Social Welfare be the sponsor, or should some way be found to bring about joint sponsorship for meeting the client's needs?

Professional Training; Volunteers

The ILRP provides field work for graduate Social Work students from the University of California School of Social Welfare, and for graduate Rehabilitation Counseling Curriculum students from S.F. State College. In addition, field work is provided for undergraduate social work students and Special Education students from S.F. State College. Two full time VISTA Volunteers have been assigned to ILRP since Spring 1965 to enrich the program of training and counseling. A dedicated group of day-to-day volunteers have contributed many hours of service in the work-training area.

Financial Support

The ILRP has been financed by a combination of support: (a) a Federal grant under the Research and Demonstration Program of the Vocational Rehabilitation Administration to SF Aid Retarded Children, Inc., in partial support of the financial cost; (b) two full-time Work Supervisors assigned by the Adult Education Division of the San Francisco Public Schools; (c) Psychiatric Consultation provided by the Community Mental Health Services, S.F. City and County Department of Public Health; (d) Consultation and assistance from the State Department of Rehabilitation, Division of Vocational Rehabilitation; (e) partial fees for Aid to Disabled (ATD) clients from the S.F. City and County Department of Social Services (through State Department of Social Welfare); (f) since Spring, 1965, two full-time VISTA (Volunteers in Service to America) staff under provisions of the Federal Economic Opportunity Act (Anti-Poverty Bill of 1964); (g) fees for services from parents of enrollees (based on their ability to pay); (h) financial contribution of matching funds from S.F. Aid Retarded Children, Inc.

Program Evaluation

Program evaluation is concerned with the effects of the program on enrollees and their families, as well as with the impact of the program on broader community services for the retarded of which the ILRP is an integral part.

Disposition of Enrollees on Termination from Program

In terms of actual disposition of enrollees on termination from the ILRP, 23% (13 out of 56 terminated enrollees) have been vocationally rehabilitated as either being employed full time in a sheltered workshop, being employed part-time, or placed in on-the-job training (OJT) as a helper in a nursing home under supervision of the State Department of Rehabilitation prior to job placement. Of the remainder, 23 were placed in the Adult Training Center, a program for social training of severely retarded adults, with only limited provision for gainful employment.

ILRP Social Competency Ratings

As for staff ratings on items of the ILRP Social Competency Ratings (See Appendix C) with a few exceptions there were no great differences in ratings from the initial rating two months after admission and about 6 months later. Some improvements were noted in a greater independence, and in the use of social services.

There were many differences in ILRP Social Competency Ratings between enrollees rated as "higher vocational potential" as compared with those rated as "lower vocational potential", with the former group receiving generally higher ratings.

"Global" Ratings of Improvement of Enrollees

In terms of global ratings of "Improvement" among 51 enrollees, as independently evaluated by 3 ILRP Staff members, there was substantial agreement that most enrollees had improved either slightly or greatly.

Other Findings

In a preliminary study of ratings and reratings over a period of 14 months on the ILRP Social Competency Ratings of a small group of 14 enrollees by their parents in 1962, there was improvement noted so far as participation in activities at home, and general self-care and independence.

None of the ILRP enrollees was returned to the State Hospital for the retarded either during enrollment or on termination from the program. Four were referred to a state hospital for the mentally ill owing to severe emotional disturbance.

Some Unique Aspects of ILRP

The ILRP is the only VRA project to test the feasibility of meeting the needs of seriously handicapped mentally retarded adults through appropriate evaluation, training, and counseling. The project has demonstrated conclusively that many of these previously neglected handicapped persons do possess varying degrees of vocational potential, and that some are capable of full-time job placement in the community.

This project is unique in its emphasis on involvement of parents and responsible relatives through counselling with staff social workers. The closest equivalent is the requirement in child guidance clinics that a disturbed child client will receive therapy only if the parents are treated at the same time. That social services has an important role in rehabilitation programs seems self evident to many, but there are few reports in the literature of social workers participating actively in vocational rehabilitation of the retarded. After our experience in this project there is little question that social work has a major contribution to make in rehabilitation of seriously handicapped retarded adults.

This project is unique in that is was conceived as a total experience approach, in which the enrollee lives as full a life as possible in a therapeutically oriented setting in which work, leisure time activities, home making, socialization and specialized training are available to suit individual needs. This concept of a total approach to the needs of the severely retarded adult is being used in several programs including the rehabilitation centers for the retarded and other severely handicapped being developed by the California State Department of Rehabilitation, such as the one being established at Agnews State Hospital.

CHAPTER 15

RECOMMENDATIONS

These recommendations are directed primarily to those who will be involved in continuing the ILRP in San Francisco. They may prove helpful to those who are planning to establish similar programs in other communities.

It is recommended that:

1. The ILRP be continued as an integral part of the comprehensive coordinated community-wide program for meeting the needs of m.r. adults in San Francisco.

2. The ILRP be expanded to include seriously handicapped adults who are physically and emotionally handicapped, in addition to those who are mentally retarded. This would require some adaptation of program for a more heterogeneous group than has been served until now.

3. A joint committee (or some other working relationship) be established including the ILRP, the Public Schools, the State Department of Rehabilitation, which would assume responsibility for bridging the present gap between school programs and ILRP. Counseling of prospective applicants to the ILRP would take place while the m.r. student is still in school.

4. A joint committee (or some other working relationship) be established including the ILRP, staff of State Department of Mental Hygiene (both hospital staff and Bureau of Social Work) which would assume responsibility for bridging the gap between the state hospital for the retarded and ILRP. This group would be concerned not only with how to move patients from the State hospital to the community, but with how to prevent inappropriate commitment of seriously handicapped m.r. adults from the community to the State hospital.

5. The close working relationship between the ILRP and the State Department of Rehabilitation be continued and further strengthened. This can be accomplished by D.R. purchasing services from ILRP; assuming greater responsibility for intake into ILRP (in cooperation with ILRP Intake Worker); conducting psychological evaluations of new enrollees; D.R. counselors attending case reviews; psychiatric consultations and staff meetings; D.R. counselors providing service to enrollees on the premises of ILRP. This approach would more functionally integrate the D.R. counselor into the ILRP rehabilitation team.

6. The present staffing pattern, including administration, training staff, social workers, consultants, and full-time VISTA volunteer staff be continued, adding a part-time clinical psychologist in residence, and continuing the supporting services of selected, trained volunteers.

7. The enrollee daily schedule of 6½ hours be continued with flexible adjustment of schedules to suit individuals. Those enrollees who can tolerate a longer work day would be provided this opportunity under special supervision.

8. The ILRP workshop be continued in the same physical area as the SFCRW. This arrangement would make it possible to be a part of a more industrial setting, and to observe and learn from work habits and skills of more able clients. It also would make possible the transfer to SFCRW of those enrollees who could tolerate more industrial pressure and a longer work-day.

9. Close working relationships with the SFCRW be continued. Up to this point only the ILRP Workshop (including contract procurement) has been articulated with the SFCRW. It is possible that other ILRP services could be set up in such a way as to serve SFCRW clients.

10. The Leisure Time Activities be continued as an integral part of the program with flexibility in assignment according to individual needs. Emphasis would be given to the pre-vocational possibilities of leisure time activities, such as furniture refinishing and Christmas decorations.

11. The Home-Centered Activities be continued as an integral part of the program, with flexibility in assignment according to individual needs. A realistic program would provide for a physical layout of a typical apartment with appropriate appliances and equipment. Training in shopping, making change, meal preparation, tidying and cleaning, as well as in functional academic skills such as reading, writing, and number concepts, would be applicable to this area. Emphasis would be given to pre-vocational possibilities leading to part-time or full-time jobs as helpers in rest homes, aides in pre-school and nursery school programs, etc.

12. Pre-Vocational Training as Messenger and Janitor be continued. The janitorial training would provide for practice in cleaning not only the ILRP areas, but other areas such as offices and homes, with training leading to part-time or full-time jobs as helpers in yard-work, helpers to gardeners, and assistant janitors. The messenger training would provide for more complex assignments through transporting letters and small parcels to various places, including "drops" at other programs than those conducted by SFARC.

13. Tutoring in academic subjects be continued and greatly expanded, especially in relation to reading, writing and number skills required by enrollees within the ILRP and in life situations beyond the daily program. For example, if counting

and measuring is required to do an assignment in the Workshop, tutoring would be provided for this purpose.

14. Measurement of changes in psycho-social adjustment and in productivity be developed in close cooperation with the staff. A research project focussing primarily on this subject could be undertaken. The ILRP Social Competency Ratings would be further tested and validated as a tool for measuring changes in enrollees in areas with which the staff is concerned.

15. Additional staff time be provided to supervise volunteers, including VISTA Volunteer staff.

16. Field work in the ILRP for students in social work, rehabilitation counseling and special education be expanded. The assignment to ILRP of part-time and full-time field work supervisors in residence (as has been done by the University of California School of Social Welfare) could serve as a basis for similar assignments in professional disciplines.

17. Information about the ILRP and its services continue to be made available on a systematic basis to the professional community, and to parents of seriously handicapped m.r. adults. This would include listing in directories of programs for the retarded and public discussions before service clubs and PTA groups.

18. The major costs of providing services be assumed by one agency, the State Department of Rehabilitation, under the provisions of PL 89-333. In addition opportunities should be open for contributions to the program of staff, equipment, or funds which the Department of Rehabilitation cannot legally provide, but which are necessary for an enriched socialization program. This should be done in cooperation with the D.R. with no intention of replacing or reducing D.R.'s contributions.

(Recommendations No. 19-28, concerned with Social Services in the ILRP, were prepared by Arthur Segal, M.S.W. - see Chapter 6 above).

It is recommended that:

19. The intake process be continued with an emphasis on exploring the client's previous medical, social and educational history for the purpose of greater understanding of the client. Recorded referral material from other agencies should not be used exclusively to determine eligibility for the ILRP or to evaluate ability to benefit from the ILRP.

20. The Initial Evaluation period to observe the client's strengths and limitations be lengthened to three months, instead of the present 8 weeks.

21. A transportation system be installed for the more severely retarded who cannot learn to travel alone, and VISTA staff and community volunteers be used for travel training prior to admission.

22. An exploratory study be made to determine ways to provide service to members of minority groups and to those m.r. who are members of families who cannot involve themselves in the ILRP, owing to transportation and other problems.

23. Each enrollee be a member of a club group as part of and appropriate to the total treatment plan; the club groups be activity-focussed to help the enrollees learn how to live and share as a group; these groups focus on emotional problems of enrollees as they arise from the membership.

24. Program media be used for their value in helping the club group and individual enrollees develop in contrast to their use as a tool to develop recreational skill; the Newspaper Group be continued to help enrollees share ideas and expressions of opinion; the Newspaper help stimulate discussion of current interest among the larger enrollee group.

25. The Enrollee Council be re-activated as the enrollee population returns to its original size of 32 enrollees; the Enrollee Council assume responsibility for sharing in planning and evaluating of the program.

26. The Lounge be continued as a treatment activity with sufficient space for both large and intimate recreational activities, and conducted physically separated from any work training activities to permit greatest freedom of expression as well as privacy from individuals not involved in the program.

27. Each enrollee have scheduled meetings with his social worker; the interviews be flexible in length; the social worker be continuously involved in enrollee activities so that he is sufficiently aware of the enrollee's problems to intervene immediately at times of crisis; the social worker be prepared to use various means to develop a relationship with the enrollee and to engage him in a treatment plan; the social worker be prepared to move with the enrollee outside the formal office setting for the interview; the content of the material discussed with enrollees be of a concrete nature, with abstract implications of problems given meaning in terms the enrollee can understand.

28. Individual counseling to parents continue to be offered during intake; group methods be used with parents after this period; parents who are not able to participate in a family or parent group receive individual counseling by ILRP staff as needed.

(Recommendations No. 29-35, addressed to agencies, organizations and individuals who have community organization responsibilities relating to the broad general goals of ILRP, were prepared by Mrs. Margarete Connolly - See Chapter 8 above).

It is recommended that:

29. The rehabilitation leadership find a way to step up, through deliberate planning and action, current efforts to integrate Health, Education, Rehabilitation and Welfare services on the local level with a goal of total rehabilitation for the client.

30. We consciously examine old attitudes while planning and taking action in the face of today's facts: automation, cybernation and gradually broadening acceptance of the principle of the right of every man to food, shelter and those other necessities which meet his basic human needs.

31. We take steps to resolve the nation-wide indecision in regard the role of social work in the rehabilitation process, and concurrently resolve the related question: who is the client? Can Rehabilitation, in many instances, achieve long-lasting results without considering, in depth, the involved members of the family which has a handicapped member? Is there wide-spread acceptance of the frequently mouthed concept that social rehabilitation is an essential base to sound vocational rehabilitation?

32. We find a way to resolve the question of the distinction between the workshop and the activity center programs, and whose is the responsibility for support. Where does the goal of one differ from the role of the other and where do they overlap? In the light of automation this becomes a crucial question.

33. VRA and NARC jointly sponsor a series of institutes throughout the United States in order to clarify local, state and federal responsibility in relation to the multiple use of workshops for the mentally retarded. Such institutes would permit dialogue between the lay and professional community and would encourage freedom of discussion in planning for people in the large-scale, large-concept range which we use in planning for such things as water resources, highways and manufactured items.

34. All of these recommendations be related to the emerging Master Plan for Rehabilitation which will be ongoing in each State and which is about to be launched in California.

35. We share the responsibility to design programs built on the premise that these community organization recommendations will be carried out.

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APPENDIX A. TABLES

TABLE 1. REFERRAL SOURCES FOR 75 ILRP ENROLLEES (1961-1965)

REFERRAL SOURCE	NO. OF REFERRALS
Board of Education (SF Unified School District)	4
SF Department of Social Services	5
State Division of Vocational Rehabilitation	14
State Department of Mental Hygiene (Bureau of Social Work)	12
SF Department of Public Health, Community Mental Health Services	3
University of California Medical Center, SF	2
SFARC Adult-Training Center (up to Sept. 1963 only)	11
SF Community Rehabilitation Workshop	1
Self-referred (newspaper publicity, etc.)	9
SFARC Member or Staff Member	7
Miscellaneous (one each: Private Physician; SF Speech and Hearing Clinic; Kaiser Hospital; YWCA; Children's Health Home (San Mateo); Jewish Family Service Agency; Lucinda Weeks School)	7
Total	75

TABLE 2. CHRONOLOGICAL AGE ON ADMISSION OF 75 ILRP ENROLLEES (1961-1965)

Chronological Age	No. of Enrollees
34-0 to 34-11	2
33-0 to 33-11	2
32-0 to 32-11	0
31-0 to 31-11	1
30-0 to 30-11	0
29-0 to 29-11	4
28-0 to 28-11	0
27-0 to 27-11	2
26-0 to 26-11	3
25-0 to 25-11	2
24-0 to 24-11	2
23-0 to 23-11	3
22-0 to 22-11	7
21-0 to 21-11	3
20-0 to 20-11	6
19-0 to 19-11	14
18-0 to 18-11	19
17-0 to 17-11	5
Total	75

TABLE 3. LEVELS OF MEASURED INTELLIGENCE (BASED ON AAMD NOMENCLATURE[1]) OF 75 ILRP ENROLLEES (1961-1965)

Levels of Measured Intelligence		No. of Clients
Level I	Borderline Retardation (1.01 to 2.00 S.D.[2] below I.Q. 100; S.B.[3] I.Q. 68-83; W-B[4] I.Q. 70-84)	3
Level II	Mild Retardation (2.01 to 3.00 S.D. below I.Q. 100; S.B. I.Q. 52-67; W-B I.Q. 55-69)	30
Level III	Moderate Retardation (3.01 to 4.00 S.D. below I.Q. 100; S.B. I.Q. 36-51; W-B I.Q. 40-54)	25
Level IV	Severe Retardation (4.01 to 5.00 S.D. below I.Q. 100; S.B. I.Q. 20-35; W-B I.Q. below 40)	16
Level V	Profound Retardation (more than 5.00 S.D. below I.Q. 100; S.B. I.Q. below 20)	1
	TOTAL	75

[1] Rick Heber, ed., A Manual on Terminology and Classification in Mental Retardation, Monograph Supplement, American Journal of Mental Deficiency, LXIV (1959) No. 2.
Rick Heber, "Modifications in the Manual on Terminology and Classification in Mental Retardation", American Journal of Mental Deficiency, LXV (1961) 499-500

[2] S.D. is "Standard Deviation" assumed to be 16.0 I.Q. points.

[3] S.B. is "Stanford-Binet Intelligence Test"

[4] W-B is "Wechsler-Bellevue Intelligence Test"

TABLE 4. LEVELS OF MEASURED SOCIAL COMPETENCE[1] (DERIVED FROM SOCIAL QUOTIENT SCORES OF VINELAND SOCIAL MATURITY SCALE[2]) OF 45 ILRP ENROLLEES[3] (1961-1965) FOR WHOM SCORES WERE AVAILABLE

Levels of Measured Social Competence		No. of Clients
Level I	No retardation of social competency (less than 1.00 Standard Deviation (S.D.)[4] below Social Quotient (S.Q.)[5] 100; S.Q. above 84	1
Level II	Mild but apparent and significant negative deviation from norms and standards of social competence (1.01 to 2.25 S.D. below S.Q. 100; S.Q. 64-83); capable of social and vocational adequacy with proper education and training. Frequently needs supervision and guidance under serious social or economic stress	4
Level III	Moderate but definite negative deviation from norms and standards of social competence (2.26 to 3.50 S.D. below S.Q. 100; S.Q. 38-63); capable of self-maintenance in unskilled or semi-skilled occupation; needs supervision when under mild social or economic stress	36
Level IV	Severe negative devision from norms and standards of social competence (3.51 to 4.75 S.D. below S.Q. 100; S.Q. 25-37); can contribute partially to self-support under complete supervision; can develop self-protection skills to a minimal useful level in controlled environment.	4
Level V.	Profound negative deviation from norms and standards of social competence (more than 4.75 S.D. below S.Q. 100; S.Q. below 25); some motor and speech development; totally incapable of self-maintenance; needs complete care and supervision.	0
	Total	45

(continued on next page)

Table 4 (continued)

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[1] Rick Heber, ed., A Manual on Terminology and Classification in Mental Retardation, Monograph Supplement, American Journal of Mental Deficiency, LXIV (1959) No. 2.
Rick Heber, "Modifications in the Manual on Terminology and Classification in Mental Retardation", American Journal of Mental Deficiency, LXV (1961) 499-500.

[2] Edgar Doll, Manual of Directions of the Vineland Social Maturity Scale, Minneapolis, Minn., Educational Test Bureau, 1947.

[3] No Social Quotients were available for 30 enrollees (see Chapter 12 for explanation).

[4] S.D. is "Standard Deviation".

[5] S.Q. is "Social Quotient", see Edgar Doll, ibid.

TABLE 5. FREQUENCY OF SCORES ON WIDE-RANGE ACHIEVEMENT TEST* FOR 75 ILRP ENROLLEES (1961-1965)

Grade Level	Reading	Spelling	Arithmetic
6.0 to 6.9	0	1	0
5.0 to 5.9	1	0	0
4.0 to 4.9	3	1	2
3.0 to 3.9	11	4	1
2.0 to 2.9	2	4	4
1.0 to 1.9	15	11	17
Below 1.0	16	24	24
No scores available	27	30	27
Totals	75	75	75

*Joseph Justak, Wide Range Achievement Test, Wilmington, Del.: C.J. Story Co., 1946

TABLE 6. SEX OF 75 ILRP ENROLLEES, (1961-1965)

Sex of Enrollees	No. of Enrollees
Male	45
Female	30
Total	75

TABLE 7. RACIAL ORIGIN OF 75 ILRP ENROLLEES (1961-1965)

Racial Origin of Enrollees	No. of Enrollees
Caucasian	65
Negro	9
Oriental	0
Filipino	1
Total	75

TABLE 8. FREQUENCY OF SECONDARY MEDICAL DIAGNOSES* (PRIMARY DIAGNOSIS "MENTAL RETARDATION") OF 75 ILRP ENROLLEES (1961-1965)

SECONDARY MEDICAL DIAGNOSES	NO. AFFECTED	ADDITIONAL DIAGNOSES
None given	7	0
"Chronic Brain Syndrome"	5	0
"Cerebral Palsy"	5	0
"Deformed Feet"	1	0
"Dental Problem, severe"	2	3
"Epilepsy"	3	3
"Hearing Defect"	2	0
"Mongolism (Down's Syndrome)"	11	0
"Obesity"	4	4
"Personality Disorder" (psychiatric diagnosis)	17	0
"Visual Defect"	5	1
"Dermatitis"	1	1
"Asthma"	0	1
"Speech Defect (Severe)"	4	17
"Venereal Disease"	1	0
"TB"	0	1
"Hypoparathyroidism"	1	0
"Alcoholism"	1	0

*Based on medical records available prior to admission, and on medical reports while enrolled. In many instances the illness was reported as being in remission at time of admission.

TABLE 9. ESTIMATE OF DEGREE OF PHYSICAL HANDICAP* OF VISUAL ACUITY AMONG 75 ILRP ENROLLEES, (1961-1965) (BASED ON STAFF OBSERVATION AND MEDICAL RECORDS.

ESTIMATED DEGREE OF PHYSICAL HANDICAP		NO. OF ENROLLEES
Severe:	Totally Blind; Almost Blind	0
Moderate:	Quite handicapped in seeing; vision not correctible by glasses	3
Mild:	Some correction needed, may weaf glasses, not handicapped in seeing	19
None:	No trouble with vision; no glasses needed	53
	Total	75

*Katz, 1956

TABLE 10. ESTIMATE OF DEGREE OF PHYSICAL HANDICAP* OF HEARING ACUITY AMONG 75 ILRP ENROLLEES, (1961-1965) (BASED ON STAFF OBSERVATION AND MEDICAL RECORDS

ESTIMATED DEGREE OF PHYSICAL HANDICAP		NO. OF ENROLLEES
Severe:	Totally deaf; almost deaf	2
Moderate:	Quite handicapped in hearing, has difficulty with hearing aid	0
Mild:	Some difficulty in hearing; may wear hearing aid satisfactorily	0
None:	No trouble with hearing	73
	Total	75

*Katz, 1956

TABLE 11. ESTIMATE OF DEGREE OF PHYSICAL HANDICAP* OF SPEECH (INTELLIGIBILITY TO OTHERS) AMONG 75 ILRP ENROLLEES (1961-1965) (BASED ON STAFF OBSERVATION.

ESTIMATED DEGREE OF PHYSICAL HANDICAP		NO. OF ENROLLEES
Severe:	Totally without speech; almost unable to communicate by speech; may use words but speech not understood by anyone	3
Moderate:	Speech hard for immediate family, close friends and/or peers to understand; hard to get ideas across in speech	13
Mild:	Speech usually understood by immediate family, close friends and/or peers, but not by strangers; does not use sentences or carry on a conversation	12
None:	Speech understood by family and by strangers; carries on normal conversation	47
	TOTAL	75

*Katz, 1956

TABLE 12. ESTIMATE OF DEGREE OF PHYSICAL HANDICAP* OF ARM-HAND USE AMONG 75 ILRP ENROLLEES (1961-1965) (BASED ON STAFF OBSERVATION ONLY)

ESTIMATED DEGREE OF PHYSICAL HANDICAP		NO. OF ENROLLEES
Severe:	Unable to use arms and hands for any self-help activities	0
Moderate:	Quite handicapped in using arms and hands for many self-help activities	1
Mild:	Some difficulty in using arms and hands for self-help but not handicapped in doing so	6
None:	No difficulty in using arms and hands for self-help activity	68
	TOTAL	75

*Katz, 1956

TABLE 13. ESTIMATE OF DEGREE OF PHYSICAL HANDICAP* OF SITTING BALANCE AMONG 75 ILRP ENROLLEES (1961-1965) (BASED ON STAFF OBSERVATION)

ESTIMATED DEGREE OF PHYSICAL HANDICAP		NO. OF ENROLLEES
Severe:	Unable to maintain sitting balance unless fully supported	0
Moderate:	Quite handicapped in sitting in a chair or at table; needs a relaxation chair and tray	0
Mild:	Some difficulty in sitting in a chair or at table, but not handicapped in doing so	0
None:	No difficulty in sitting in a chair or at table	75
	TOTAL	75

*Katz, 1956

TABLE 14. ESTIMATE OF DEGREE OF PHYSICAL HANDICAP* OF WALKING AMONG 75 ILRP ENROLLEES (1961-1965) (BASED ON STAFF OBSERVATION)

ESTIMATED DEGREE OF PHYSICAL HANDICAP		NO. OF ENROLLEES
Severe:	Unable to walk	0
Moderate:	Quite handicapped in walking; cannot walk independently	0
Mild:	Braces needed; unsteady gait, but able to get about	3
None:	No difficulty in walking	72
	TOTAL	75

*Katz, 1956

TABLE 15. ESTIMATE OF ADEQUACY OF CURRENT INCOME AT TIME OF ADMISSION TO PROGRAM FOR 75 ILRP ENROLLEES (1961-1965)

ESTIMATED ADEQUACY OF INCOME AT ADMISSION	NO. OF ENROLLEES
Some income, inadequate for basic needs	7
Adequate income for basic needs, inadequate to pay fees for rehabilitation services in ILRP	42
Adequate income for basic needs and to pay fees for rehabilitation services in ILRP	26
TOTAL	75

TABLE 16. OCCUPATION OF HEAD OF HOUSEHOLD IN WHICH 75 ILRP ENROLLEES LIVED PRIOR TO ADMISSION TO PROGRAM (1961-1965)

OCCUPATION OF HEAD OF HOUSEHOLD	NO. OF ENROLLEES
Welfare recipient, pensioner, with income adequate only for basic needs	12
Unemployed	2
Housewife	4
Unskilled worker, laborer, domestic, farmer	12
Skilled worker, semi-skilled trades	19
Lesser professional, technicians, sales, office, clerical	9
Professional, managerial, owner of substantial business	8
Family Care Home or Foster Home	9
TOTAL	75

TABLE 17. MAJOR SOURCE OF SUPPORT (INCOME FOR 75 ILRP ENROLLEES (1961-1965)

MAJOR SOURCE OF SUPPORT	NO. OF ENROLLEES
Public Assistance (Aid to the Disabled, (ATD), Aid to Families with Dependent Children (AFDC), Aid to Needy Blind (AND))	14
Social Security Benefits, Veterans Administration Benefits	6
Family Income Only	26
Public Assistance and Social Security or VA benefits	4
Public Assistance and Family Income	19
Public Assistance, Social Security and Family Income	1
Social Security or VA benefits and Family Income	4
Annuities, Savings, property, investments	1
TOTAL	75

TABLE 18. FAMILY ROLE POSITION OF 75 ILRP ENROLLEES (1961-1965)

FAMILY ROLE POSITION	NO. OF ENROLLEES
Son	35
Male Relative	3
Wife	1
Daughter	26
Family Care Home	10
TOTAL	75

TABLE 19. LIVING ARRANGEMENTS OF 75 ILRP ENROLLEES (1961-1965)

LIVING ARRANGEMENTS	NO. OF ENROLLEES
With mother only (no siblings, no father)	6
With mother and one or more siblings	11
With father only (no siblings, no mother)	2
With father only and one or more siblings	1
With parents only (no siblings or other children in home)	12
With parents and one or more siblings or other children)	23
With adult relatives and one or more other children)	3
In family care home	12
With grandparents and one or more siblings	1
With husband	1
TOTAL	75

TABLE 20. EDUCATIONAL HISTORY OF 75 ILRP ENROLLEES (1961-1965)

EDUCATIONAL HISTORY OF ENROLLEE	NO. OF ENROLLEES
Unknown (no records available)	1
Never attended school	1
Excluded from school prior to normal termination (at 16 or 18 years)	2
In State Hospital for retarded, attended school there	6
Attended classes in State Hospital for retarded, and in public school	4
Home teacher (most of schooling)	1
Home teacher and public school classes	1
Special classes for Trainable Mentally Retarded (TMR) only	35
Special classes for TMR and Educable Mentally Retarded (EMR)	3
Special Classes for EMR only	12
Special Classes for Orthopedically Handicapped	1
Regular Classes (public and/or private and/or parochial schools)	4
Special Classes for Deaf	2
Private schools or private institution for retarded	2
TOTAL	75

TABLE 21. HISTORY OF VOCATIONAL REHABILITATION SERVICES PROVIDED PRIOR TO ADMISSION FOR 75 ILRP ENROLLEES (1961-1965)

HISTORY OF VOCATIONAL REHABILITATION SERVICES	NO. OF ENROLLEES
No information available	37
Evaluated by State Division of Vocational Rehabilitation (DVR)- not accepted	20
Evaluated by State DVR - accepted	1
Attended SF ARC Work-Training Center project (1957-1961) (admitted up to September 1963 only)	10
Attended SF Community Rehabilitation Workshop (formerly Morrison Rehabilitation Center Workshop)	2
Attended other sheltered workshop	5
TOTAL	75

TABLE 22. EMPLOYMENT STATUS PRIOR TO ADMISSION OF 75 ILRP ENROLLEES (1961-1965)

EMPLOYMENT STATUS PRIOR TO ADMISSION	NO. OF ENROLLEES
Never Employed	60
Sheltered workshop, long-term	11
Sheltered workshop, transitional, (short-term)	2
Employed, intermittently	1
Employed, part-time	1
TOTAL	75

TABLE 23. HISTORY OF PREVIOUS HOSPITALIZATION AND/OR PSYCHIATRIC CARE AMONG 75 ILRP ENROLLEES (1961-1965)

PREVIOUS HOSPITALIZATION AND/OR PSYCHIATRIC CARE	NO. OF ENROLLEES
No record of prior inpatient admission to State Hospital, private institution, or outpatient psychiatric treatment	40
Prior admission to State Hospital or Private Institution for mentally retarded (90 day and/or extended commitment)	26
Prior admission to State Hospital or Private Institution for mentally ill (90 day and/or extended commitment)	5
Prior outpatient psychiatric treatment	3
Outpatient psychiatric treatment and hospitalization	1
TOTAL	75

TABLE 24. DISPOSITION OF 56 ENROLLEES AT TIME OF TERMINATION FROM ILRP (1961-1965)

DISPOSITION AT TERMINATION	NO. OF ENROLLEES
Placed in SF Community Rehabilitation Workshop*	5
Waiting for admission to SF Community Rehabilitation Workshop	1
Full-time Job in S.F. Goodwill Industries	1
Employed part-time	3
On-the-Job Training Program under State Dept. of Rehabilitation**	3
SFARC Adult Training Center	23
State Hospital for Mentally Retarded	0
State Hospital for Mentally Ill	4
Referred back to parent or responsible relative (including those who were withdrawn by family, or moved from San Francisco)	16
TOTAL	56

* One now employed full-time as busboy.

**Two now employed full-time as helper in convalescent home.

Note: Of 19 enrollees in ILRP as of August 1, 1965, 2 are employed part-time on janitorial jobs outside ILRP, and 1 is employed full-time as assistant to the work supervisor ("leader man") in the ILRP Workshop.

TABLE 25. RATINGS AND RE-RATINGS OF 40 ILRP ENROLLEES AT 6-MONTH INTERVALS (1964-1965) ON REVISED ILRP SOCIAL COMPETENCY RATINGS*

ITEM**	1st RATING	2nd RATING
5 Punctuality		
4	35	32
3	1	2
2	1	1
1	3	5
No rating	0	0
	40	40
6 Attendance		
4	31	28
3	4	5
2	3	5
1	2	2
No rating	0	0
	40	40
7 Grooming		
4	22	18
3	11	15
2	7	6
1	0	1
	40	40
8 Comprehension		
4	14	8
3	22	27
2	4	4
1	0	1
No rating	0	0
	40	40
9 Concentration		
4	17	8
3	17	23
2	6	8
1	0	1
No Rating	0	0
	40	40
10 Consideration for Others		
5	0	1
4	18	8
3	17	25
2	5	3
1	0	3
No rating	0	0
	40	40

ITEM	1st RATING	2nd RATING
11 Self-Care		
5	31	29
4	5	8
3	3	3
2	0	0
1	1	0
No rating	0	0
	40	40
12 Self-Image		
5	3	5
4	19	12
3	8	8
2	7	10
1	2	5
No rating	1	0
	40	40
13 Speed of Work		
6	1	2
5	5	3
4	11	3
3	11	16
2	11	10
1	0	3
No rating	1	3
	40	40
15 Accuracy of Workmanship		
4	4	7
3	31	27
2	3	5
1	0	0
No rating	2	1
	40	40
16 Care of Tools		
5	8	6
4	26	27
3	2	5
2	2	0
1	0	1
No rating	2	1
	40	40

(continued)

TABLE 25 (continued)

ITEM	1st RATING	2nd RATING
17 Independence from Supervision		
4	0	2
3	23	27
2	17	9
1	0	0
No rating	0	2
	40	40
18 Mastery of crafts		
7	2	3
6	1	0
5	17	16
4	8	10
3	2	3
2	4	3
1	1	0
No rating	5	5
	40	40
19 Exploration of Leisure Time Activities		
4	3	6
3	19	18
2	11	11
1	1	0
No rating	6	5
	40	40
20 Food Prepartion		
5	3	2
4	20	21
3	5	5
2	4	1
1	3	2
No rating	5	9
	40	40
21 Setting table		
3	30	30
2	3	0
1	0	1
No rating	7	9
	40	40
22 Washing dishes		
4	29	31
3	3	2
2	1	1
1	0	1
No rating	7	5
	40	40
23 Bed making		
3	29	30
2	3	2
1	1	1
No rating	7	7
	40	40
24 Ironing		
5	4	5
4	24	22
3	1	0
2	2	2
1	0	1
No rating	9	10
	40	40
25 Room cleaning		
3	11	18
2	20	16
1	0	0
No rating	9	6
	40	40
26 Shopping		
5	5	9
4	12	8
3	12	9
2	2	1
1	3	1
No rating	6	12
	40	40
27 Independent Travel		
4	24	24
3	1	0
2	2	1
1	2	3
No rating	11	12
	40	40

(continued)

TABLE 25 (continued)

ITEM	1st RATING	2nd RATING
29 Money Management		
5	1	0
4	6	0
3	27	26
2	2	2
1	1	1
0	3	11
No rating	0	0
	40	40
30 Reading		
5	1	1
4	9	9
3	5	4
2	8	6
1	9	10
No rating	8	10
	40	40
31 Number Concept		
4	16	20
3	5	3
2	1	8
1	2	3
No rating	16	6
	40	40
32 Writing		
5	2	6
4	7	2
3	8	3
2	6	4
1	3	7
No rating	14	18
	40	40
33 Telling Time		
4	11	10
3	7	3
2	5	2
1	10	13
No rating	7	12
	40	40
34 Use of Social Case Work		
4	2	5
3	17	18
2	15	7
1	3	5
No rating	3	5
	40	40
35 Use of Group Work		
5	17	17
4	12	14
3	3	5
2	7	0
1	0	3
No rating	1	1
	40	40
36 Identification with Group		
4	13	15
3	12	12
2	9	7
1	6	5
No rating	0	1
	40	40
37 Interaction within Family		
5	9	6
4	2	6
3	8	8
2	19	17
1	2	1
No rating	0	2
	40	40
38 Parent Attitudes to Enrollee		
4	15	11
3	15	17
2	4	4
1	3	3
No rating	3	5
	40	40

(continued)

TABLE 25 (continued)

* See Appendix C for form used.

** This table should be read as follows: "On item 5. *Punctuality - morning starting time*, on their *first* rating, 35 enrollees (out of 40 enrollees) were rated as *never or almost never late - no more than once a year*; 1 enrollee was rated as *rather rarely late - about once every two or three months;* 1 enrollee was rated as *occasionally late - no more than once every two weeks;* 3 enrollees were rated as *frequently late one or more times a week*. On their *second* rating, 32 enrollees (out of 40 enrollees) were rated as *never or almost never late - no more than once a year*; 2 enrollees were rated as *rather rarely late - about once every two or three months*; 1 enrollee was rated as *occasionally late - no more than once every two weeks*; 5 enrollees were rated as *frequently late - one or more times a week.* On Item 6 *Attendance: absenteeism*, on their *first* rating 31 enrollees (out of 40 enrollees) etc...."

TABLE 26. RATINGS OF 13 ILRP ENROLLEES WITH "HIGHER VOCATIONAL POTENTIAL" COMPARED WITH 13 ILRP ENROLLEES WITH "LOWER VOCATIONAL POTENTIAL" (1964-1965) ON ILRP SOCIAL COMPETENCY RATINGS*.

ITEM	HIGHER VOCATIONAL POTENTIAL GROUP	LOWER VOCATIONAL POTENTIAL GROUP
5 Punctuality		
4	13	10
3	0	2
2	0	0
1	0	1
No rating	0	0
	13	13
6 Attendance		
4	11	10
3	1	2
2	1	0
1	0	1
No rating	0	0
	13	13
7 Grooming		
4	8	7
3	2	4
2	2	2
1	0	0
No rating	1	0
	13	13
8 Comprehension		
4	0	5
3	10	7
2	1	1
1	2	0
No rating	0	0
	13	13
9 Concentration		
4	0	4
3	8	8
2	4	1
1	1	0
No rating	0	0
	13	13
10 Consideration for others		
5	0	0
4	2	3
3	9	9
2	0	1
1	2	0
No rating	0	0
	13	13
11 Self-Care		
5	5	13
4	5	0
3	3	0
2	0	0
1	0	0
No rating	0	0
	13	13
12 Self-Image		
5	0	5
4	2	4
3	1	3
2	5	1
1	5	0
No rating	0	0
	13	13
13 Speed of Work		
6	0	1
5	0	3
4	0	3
3	5	6
2	5	0
1	3	0
No rating	0	0
	13	13

(continued)

TABLE 26 (continued)

ITEM	HIGHER VOCATIONAL POTENTIAL GROUP	LOWER VOCATIONAL POTENTIAL GROUP
15 Accuracy of Workmanship		
4	0	4
3	8	9
2	4	0
1	0	0
No rating	1	0
	13	13
16 Care of tools		
5	0	6
4	10	6
3	1	1
2	0	0
1	1	0
No rating	1	0
	13	13
17 Independence from supervision		
4	0	2
3	6	10
2	6	1
1	0	0
No rating	1	0
	13	13
18 Mastery of Crafts		
7	0	1
6	0	0
5	3	7
4	4	2
3	2	0
2	3	0
1	0	0
No rating	1	3
	13	13
19 Exploration of Leisure Time		
4	0	3
3	3	7
2	9	0
1	0	0
No rating	1	3
	13	13
20 Food Preparation		
5	1	0
4	6	9
3	1	1
2	1	0
1	2	0
No rating	2	3
	13	13
21 Setting table		
3	10	10
2	0	0
1	1	0
No rating	2	3
	13	13
22 Washing Dishes		
4	9	9
3	1	1
2	1	0
1	1	0
No rating	1	3
	13	13
23 Bed Making		
3	8	9
2	2	0
1	1	0
No rating	2	4
	13	13
24 Ironing		
5	1	4
4	8	6
3	0	0
2	1	0
1	1	0
No rating	2	3
	13	13

(continued)

TABLE 26 (continued)

ITEM	HIGHER VOCATIONAL POTENTIAL GROUP	LOWER VOCATIONAL POTENTIAL GROUP
25 Room Cleaning		
3	5	5
2	6	4
1	1	0
No rating	1	4
	13	13
26 Shopping		
5	0	6
4	3	2
3	5	1
2	1	0
1	1	0
No rating	3	4
	13	13
29 Money Management		
5	0	0
4	0	0
3	8	9
2	2	0
1	1	0
No rating	2	4
	13	13
30 Reading		
5	0	0
4	1	4
3	0	4
2	3	1
1	5	1
No rating	4	3
	13	13
31 Number Concept		
4	3	9
3	0	2
2	6	0
1	3	0
No rating	1	2
	13	13
32 Writing		
5	1	2
4	0	2
3	2	1
2	1	1
1	6	0
No rating	3	7
	13	13
33 Telling Time		
4	2	3
3	2	1
2	0	1
1	7	3
No rating	2	5
	13	13
34 Use of Social Case Work		
4	1	3
3	4	7
2	2	3
1	3	0
No rating	3	0
	13	13
35 Use of Group Work		
5	7	8
4	2	3
3	2	1
2	0	0
1	2	1
No rating	0	0
	13	13
36 Identification with Group		
4	3	9
3	4	1
2	4	1
1	2	2
No rating	0	0
	13	13

(continued)

TABLE 26 (continued)

ITEM	HIGHER VOCATIONAL POTENTIAL GROUP	LOWER VOCATIONAL POTENTIAL GROUP	ITEM	HIGHER VOCATIONAL POTENTIAL GROUP	LOWER VOCATIONAL POTENTIAL GROUP
37 Interaction with Family			38 Parent Attitudes toward Enrollee		
5	2	2	4	1	5
4	1	2	3	8	6
3	3	3	2	0	0
2	5	6	1	0	0
1	1	0	No rating	2	2
No rating	1	0		13	13
	13	13			

*See Appendix C for form used.

**This table should be read as follows: "On item 5 Punctuality - morning starting time, 13 "Lower Vocational Potential" enrollees (out of 13) were rated as never or almost never late - no more than once a year; while 10 "Higher Vocational Potential" enrollees (out of 13) were so rated; no "Lower Vocational Potential" enrollee was rated as rather rarely late - about once every two or three months, while 2 "Higher Vocational Potential" enrollees were so rated; no "Lower Vocational Potential" or "Higher Vocational Potential" enrollees were rated as occasionally late - no more than once every two weeks; no "Lower Vocational Potential" enrollee was rated frequently late - one or more times a week, while 1 "Higher Vocational Potential" enrollee was so rated, etc."

TABLE 27. "GLOBAL" RATING OF IMPROVEMENT OF 52 ILRP ENROLLEES, INDEPENDENTLY MADE BY THREE ILRP STAFF MEMBERS IN OCTOBER, 1965, AND COMPOSITE RATING.

	RATING					
ENROLLEE	DETERIORATION (-1)	NO IMPROVEMENT (0)	SLIGHT IMPROVEMENT (+1)	MODERATE IMPROVEMENT (+2)	GREAT IMPROVEMENT (+3)	COMPOSITE RATING*
1	0	0	1	2	0	+1.7**
2	1	2	0	0	0	-0.3
3	0	2	0	1	0	+0.7
4	0	2	1	0	0	+0.3
5	0	0	1	2	0	+1.7
6	0	0	2	1	0	+1.3
7	0	0	2	1	0	+1.3
8	0	2	1	0	0	+0.3
9	1	2	0	0	0	-0.3
10	0	0	3	0	0	+1.0
11	0	0	1	2	0	+1.7
12	0	0	0	0	3	+3.0
13	0	3	0	0	0	0
14	0	0	2	1	0	+1.3
15	0	0	2	1	0	+1.3
16	0	2	1	0	0	+0.3
17	0	3	0	0	0	0
18	0	0	2	1	0	+1.3
19	0	0	1	2	0	+1.7
20	0	0	0	2	1	+2.3
21	0	0	0	3	0	+2.0
22	1	2	0	0	0	-0.3
23	0	3	0	0	0	0
24	1	1	1	0	0	0
25	0	0	0	2	1	+2.3
26	0	0	2	1	0	+1.3
27	1	2	0	0	0	-0.3
28	0	0	1	1	1	+1.0
29	0	0	2	1	0	+1.3
30	0	3	0	0	0	0
31	0	0	2	1	0	+1.3
32	0	0	0	3	0	+2.0
33	0	0	0	3	0	+2.0
34	0	0	2	1	0	+1.3
35	0	2	1	0	0	+0.3
36	0	0	2	1	0	+1.3
37	1	1	1	0	0	0

(continued)

TABLE 27 (continued)

ENROLLEE	RATING					
	DETERIORATION	NO IMPROVEMENT	SLIGHT IMPROVEMENT	MODERATE IMPROVEMENT	GREAT IMPROVEMENT	COMPOSITE RATING*
	(-1)	(0)	(+1)	(+2)	(+3)	
38	0	0	1	0	2	+2.3
39	1	1	1	0	0	0
40	0	0	0	2	1	+2.3
41	0	1	1	1	0	+1.0
42	0	0	3	0	0	+1.0
43	0	0	0	1	2	+2.7
44	0	2	1	0	0	+0.3
45	0	2	1	0	0	+0.3
46	0	0	1	2	0	+1.7
47	0	0	2	1	0	+1.3
48	0	0	1	2	0	+1.7
49	0	2	1	0	0	+0.3
50	0	0	0	1	2	+2.7
51	0	0	0	0	3	+3.0
52	1	0	1	1	0	+1.0

*Composite Rating obtained by multiplying rating (-1.0, +1, +2, +3) by number of raters making the rating and dividing by number of raters (3 raters).

**This Table should be read, "Enrollee 1 was rated as "Slightly Improved" by 1 rater, and "Moderately Improved" by 2 raters. His Composite Rating is +1.7; Enrollee 2 was rated as "Deteriorated" by 1 rater, and "Not Improved" by 2 raters. His Composite Rating is -0.3; etc."

APPENDIX B. INDEPENDENT LIVING REHABILITATION PROGRAM CASES.

CASE 1*

Bernard W. is a tall, slender, reddish-haired young man of 24 who was a patient at Sonoma State Hospital since he was 8 years old. He dresses neatly, is well-groomed, and sports a neat mustache. When he came to us about two years ago he lived in a family care home with several other young men also on leave from state hospitals.

While in the hospital he had escaped many times, walking or riding for long distances. He could not explain why he did so, but it was believed that in his fantasy life he was seeking his mother who had abandoned him many years before.

Early in his enrollment with us he exhibited many of the same tendencies, being absent without leave and wandering. Once he was picked up as a vagrant in Sacramento and was in jail for two days until his background and status were reported to the police. He was also having trouble with his family caretaker, and with one or two of his fellow patients.

Prior to admission to our program he had no work history, other than helping out in the state hospital. Shortly after admission it was learned that he was capable of doing packaging and assembly work at a productivity level equivalent to 50% that of a non-handicapped worker doing the same work, and he was soon being paid at that rate when he worked. Being paid such a salary created problems at first, since now he had money which could be used to purchase things, as well as to finance his urge to wander away. He was almost totally devoid of any skills in using money wisely, preferring to buy unrealistically, such as expensive radios and TV sets. He also ran up a bill for his minimum fee of $1.00 per month to the agency, which he had agreed to pay when he was admitted.

As the months went by it became clearer that he could be employed full-time on a job, if he could give up his fantasy of seeking his mother, if he could assume greater responsibility for his own actions in such matters as budgeting and spending money appropriately, and if he could use his undeniable work skills to obtain and to hold a full-time job. By this time episodes of wandering and A.W.O.L. had almost disappeared.

Several months ago a crisis developed. He was having serious difficulties with his family caretaker and it appeared that he might have to be returned to the State Hospital. He had become angry with our agency for making him face up to his obligations and to pay his bills (which would have been no hardship to him). He was also showing that if he did work he could carry on more complex assembly and packaging operations, especially if allowed to work by himself.

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*Prepared by Elias Katz, Ph.D.

Suddenly he began to absent himself from the program.

By staff agreement, the Workshop Supervisor interviewed him and told him that he was doing so well on the job that he would be given a trial promotion to "Assistant Lead-Man", meaning an enrollee who helped other enrollees do their work. It was also made clear that he must meet his obligations to the agency, including paying his bill and coming regularly.

This was the turning point. He returned to work, paid his bills and no longer absented himself. A few weeks later he was doing so well at his work that the Department of Rehabilitation Counselor for the mentally retarded arranged to get him a temporary job in a small restaurant as a bus-boy and kitchen helper. This job has turned out to be a permanent full-time one for which he is being paid the minimum wage of $1.25 per hour. He occasionally returns on his day off to happily tell us about his job and about how much more he is now earning than when he was with us. The restaurant he works in is not one which would retain him if he were not able to work steadily and to meet his obligations as a worker.

CASE 2*

Mary J., an attractive 24-year old woman came to our attention when her mother responded to local newspaper publicity describing the ILRP. She had last attended public school classes for the trainable retarded. Her school reports indicated behavior problems manifested by withdrawal and shyness. She seemed awkward in her physical movements and her social approaches. We learned that Mary had a history of behavioral conflicts which appeared to stem from friction within the household. Much of this conflict could be related to the family's inability to understand her. This resulted in inappropriate expectations, disagreement as to standard-setting and poor communication with family.

Her participation during her first year at the ILRP illustrated the withdrawn behavior described by school reports. Further observation illustrated attempts to make friends using childish mechanisms. She seldom spoke to staff but would follow staff about. She had a similar relationship with peers. Her work was slow though accurate. The initial diagnostic impression as reported by the psychologist was Mental Retardation, Severe (Stanford-Binet I.Q., 46) Emotional Disturbance, Severe.

The staff formulated a treatment plan which was directed toward teaching her skills she could use at home, toward helping develop social relationship both with staff and peers and toward helping the family resolve those conflicts which centered around their relationships with her. Work with her involved encouragement to participate, an expression of staff faith that she could participate as well as a lack of pressure that she do more than follow the minimal rules of the program. Social work with her parents as a family group and then as a part of a larger parent group enabled them to recognize their daughter's strengths and limitations and to place realistic demands on participation at home. As they learned to do this they discovered they felt more comfortable with her and she found she was able to derive greater satisfaction from family participation.

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*Prepared by Arthur Segal, MSW

Her participation in the training and social group work programs started to increase as her parents learned to resolve some of their questions. She became more verbal with staff and peers and began to work more quickly at tasks. As she found she could participate in activities and could form friendships, the staff approach to her took on a new direction. Staff began to indicate their discomfort with Mary's immature attention-getting devices and indicated some adult methods which might be used. Her response indicated that she too was uncomfortable with her childish relationships with staff and would prefer the more adult kind. Though for 18 months she did not want to see a social worker, one day she asked for an appointment. The interview and those succeeding it were productively used to help Mary take the next steps. This involved reviewing the process of the two years at ILRP and planning for entrance into a long-term sheltered workshop.

The move into the long-term workshop was made with relative ease. Another psychological evaluation administered at this time provided a diagnostic impression of mental retardation, moderate, with a rise in I.Q. scores of about 15 points over the earlier score. She continues to improve and her new work supervisors have reported to our staff that she is a good worker.

CASE 3*

Lillian F. is a 20-year old negro woman, looking and dressing like a young adolescent girl, with socks, short skirts with starched ruffled petticoats. She had attended public school classes for the "trainable"mentally retarded, and had "graduated" at the age of 18 years. School reports indicated that she obtained Stanford-Binet I.Q.'s in the 40's, and that she had been a well-adjusted pupil. For reasons not explained during the summer following graduation she became very disturbed and tried to attack her mother with a knife. She was admitted to Napa State Hospital for observation, and was released with a diagnosis of "schizophrenic reaction, undifferentiated".

When she was first admitted about 2 years ago her behavior was immature and unpredictable. She could not stick to her regular assignment but insisted on going to other parts of the program. She related to only one staff member. She kept on the fringe of all groups and would not participate. Her hostility to certain staff members and enrollees was shown by unexpected punches or kicks delivered in such a way as not to be noticed until after she had moved past her victim. She also possessed a choice vocabulary of cuss words which she used frequently and loudly. At times she was observed moving her lips as though talking to someone but whether this was hallucinating was not known.

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*Prepared by Elias Katz, Ph.D.

The one area of the program she did best was in the workshop, where her skills were good. When tests of her productivity were performed it was found that she was capable of doing work up to 50-60% the productivity level of non-handicapped workers doing the same job. Poor concentration, however, meant that she was functioning well below her potential.

As months went by a noticeable change took place in her work habits. When she was having trouble with others she no longer resorted to physical aggression but restricted herself to calling them names. She was now better able to accept limitations, and her wandering finally ceased.

Then she was given an opportunity for a temporary "loan" to another rehabilitation workshop located in the same building. There she had a full work day in the company of handicapped workers who were distinctly more able in their work. She performed this assignment quite well for the agreed-on period of two weeks. When she returned to our program there was a sharp improvement in her self-assurance and her actual productivity. She can now be given any task in our workshop and she will do it almost to the level of a non-handicapped worker. Those who knew her when she first came into our program are found saying, "Look at the change in that Lillian!" Whereas our early plan was to keep her from withdrawing into herself, and to help her to become more mature, now with her newly developed self-image as a worker our present goal is to place her in a long-term sheltered workshop where she can work full-time under industrial demands, with only limited supervision. While the future prognosis is not clear, it is possible that she might hold a job in a well-supervised occupation.

APPENDIX C. INDEPENDENT LIVING REHABILITATION PROGRAM SOCIAL COMPETENCY RATINGS

CODE: ____________

NAME: ______________________________ NO: ____________ DATE: ____________ BY: ____________

Instructions:

1. Place a circle around appropriate number of category most closely applicable to enrollee.
2. If enrollee was not observed, place a circle around 0.
3. If the item is not applicable, place a circle around 9.

GENERAL:

05 0 Punctuality - morning starting time
1 Frequently late one or more times a week
2 Occasionally late - no more than once every two weeks
3 Rather rarely late - about once every two or three months
4 Never or almost never late - no more than once a year
9

06 0 Attendance; absenteeism
1 Frequently absent - one or more times a week
2 Occasionally absent - no more than once every two weeks
3 Rather rarely absent - about once every month or two
4 Never or almost never absent - no more than once a year
9

07 0 Grooming and cleanliness
1 Not clean; slovenly dressed
2 Usually unclean and not groomed; occasionally clean and well-groomed
3 Usually clean and well-groomed; occasionally not so
4 Usually clean and well-groomed
9

08 0 Comprehension and Following of Directions (General)
1 Does not comprehend or follow instructions
2 Comprehends instructions but usually does not follow them
3 Comprehends instructions and usually follows them; occasionally does not follow instructions.
4 Comprehends and follows instructions
9

09 0 Concentration and Completion of Tasks (General)
1 Does not concentrate on tasks and does not complete them
2 Concentration fluctuates and has difficulty in completing tasks
3 Concentration fluctuates but is able to complete tasks anyway
4 Concentrates on tasks and carries them through to completion
9

10 0 Consideration for Enrollees and Staff; Courtesy; Politeness
1 Inconsiderate of others; impolite; resents correction
2 Usually inconsiderate and/or impolite to others; occasionally is polite, considerate and courteous
3 Usually considerate of others' feelings; usually polite; occasionally inconsiderate and impolite
4 Very considerate of others' feelings; very polite; very cooperative with enrollees and staff
9

Social Competency Scale - page 2

11 0 Self-Care; Independence
1 Totally dependent; no self-care activities
2 Totally dependent in most areas of self-care
3 Partially independent in most areas of self-care with supervision and/or help
4 Independent in most self-care activities; requires some supervision and/or help in very few, relatively unimportant areas
5 Totally independent in all self-care activities
9

12 0 Self-Image
1 Totally distorted and unrealistic; largely unaware of what he can or cannot do; sees himself completely dependent on adults; reacts emotionally as a young child
2 Sees himself dependent on adults; speaks of an unrealistic future; sometimes expresses negative emotion towards adults
3 Sees himself dependent on adults, but does disagree with them; speaks of a realistic future
4 Sees himself as an independent adult but has unrealistic goals for himself
5 Sees himself as an independent adult able to compete in society and works towards a realistic future
9

TRAINING PROGRAM - WORKSHOP

13 0 Speed of work as compared with non-handicapped person doing the same kind of work; salary per hour
1 Very slow rate: less than 5% of rate of non-handicapped worker (Paid less than 15¢/hour)
2 Very slow rate: 6-10% of rate of non-handicapped worker (Paid 15¢ per hour - minimum wage)
3 Slow rate: 11-25% of rate of non-handicapped workers (Paid 20¢-30¢ per hour)
4 Slow rate: 26-50% of rate of non-handicapped worker (Paid 30¢-50¢ per hour)
5 Slow rate: 51-75% of rate of non-handicapped worker (Paid up to 80¢ per hour)
6 Below average rate: 76%-100% of rate of non-handicapped worker (Paid more than 81¢ per hour)
9

14 0 Quantity of Work (?)
1 Produces no measurable amount of work
2 Produces only a small amount of work
3 Produces average amount of work
4 Produces maximum results
9

15 0 Accuracy of Workmanship (with or without supervision; Quality of Work
1 No accuracy in doing work whether or not supervised
2 Usually inaccurate work, occasionally does work accurately when supervised
3 Usually accurate, occasionally does work inaccurately even when supervised
4 Extremely accurate in doing work, whether supervised or not supervised
9

16 0 Care of Tools, Materials and Equipment in Workshop
1 Has no conception of care of tools, materials and equipment
2 Is very careless with tools, materials and equipment
3 Usually careless with tools, materials and equipment, occasionally shows some care with them
4 Usually careful with tools, materials and equipment, occasionally is careless with them
5 Always very careful about the use of tools, equipment, materials
9

17 0 Independence from Supervision in Workshop and Perseverance at Job; Distractibility; Consistent Performance
1 Totally dependent on supervision; will not do any work unless closely supervised; no perseverance at job - concentrates for less than 10 minutes at a time
2 Usually needs close supervision, but occasionally can be left unsupervised for brief periods; little perseverance at task - will pay attention to job if time does not exceed half-hour
3 Occasionally works independently of supervision; occasionally needs some supervision; usually perseveres at job - will pay attention to job until finished
4 Totally independent from supervision; can be left unsupervised for extended periods of time
9

TRAINING PROGRAM -LEISURE TIME ACTIVITIES AND CRAFTS

18 0 Mastery of Crafts Taught; Carry over into Leisure Time Activities
1 Learned none of the craft procedures taught
2 Learned one or two of the craft procedures taught, but none of the others. No carry over into leisure time activities.
3 Learned one or two of the craft procedures taught, but none of the others. Some carry over into leisure time activities
4 Learned a few of the craft procedures taught, but not all. No carry over into leisure time activities
5 Learned a few of the craft procedures taught, but not all. Some carry over into leisure time activities
6 Learned all craft procedures taught. No carry over into leisure time activities.
7 Learned all craft procedures taught. Some carry over into leisure time activities
9

19 0 Exploration of Interests; Freedom of expression of ideas and feelings through medium of arts and crafts; self-confidence
1 Unwilling and unable to explore personal interests; unable to express ideas or feelings; no self-confidence
2 To a very limited degree able to explore personal interests; limited in personal expression of ideas and feelings; limited self-confidence
3 Able to explore personal interests, but limited in personal expression of ideas and feelings; some measure of self-confidence
4 Willing and able to explore personal interests; considerable freedom in personal expression in crafts; self-confidence
9

TRAINING PROGRAM - HOME-MAKING

20 0 Food Preparation
1 Does not prepare any foods
2 Prepares simple foods requiring no mixing or cooking
3 Prepares foods requiring mixing but no cooking
4 Mixes and cooks simple foods
5 Plans and cooks a simple meal
9

21 0 Table Setting
1 Does not set the table
2 Sets the table incorrectly
3 Sets the table correctly
9

22 0 Washing Dishes
1 Does not wash dishes
2 Tries to wash dishes but does too poorly to continue
3 Washes dishes but does not get them clean
4 Washes dishes well
9

23 0 Bed-making
1 Does not make bed
2 Makes the bed but makes it up incorrectly
3 Makes bed correctly
9

24 0 Ironing and Folding
1 Does not iron or fold any laundry items
2 Folds some laundry items but does no ironing
3 Folds all laundry items but does no ironing
4 Folds some laundry items and does some ironing
5 Does ironing and folding of all laundry items
9

25 0 Room Cleaning and Tidying
1 Does not sweep up or tidy rooms such as living room, bedroom
2 Does some cleaning, such as sweeping, but cleans only roughly, and does not get room clean
3 Cleans house well, including sweeping, dusting, tidying
9

26 0 Shopping
1 Does no shopping
2 Goes along with group doing shopping but does not participate in shopping activities
3 Does shopping with close supervision
4 Does shopping with only slight supervision
5 Does shopping without supervision
9

27 0 Independent Travel to Work on Public Transportation (if applicable)
1 Does not get to work on public transportation
2 Gets to work on public transportation when accompanied by an adult
3 Gets to work by public transportation but needs supervision, at beginning and/or end of trip
4 Travels alone to work on public transportation
9

28 0 Independent Travel to Work by Walking from Home within Walking Distance (if applicable)
1 Does not walk to work from home
2 Walks to work from home only if accompanied by adult
3 Walks to work from home but occasionally becomes diverted and gets into difficulties
4 Walks to work from home without any difficulties
9

29 0 Handling Money
1 Has no idea of the value of money
2 Recognizes that money has value, but does not use money
3 Uses money, but does not make change correctly
4 Makes change correctly but does not use banking facilities
5 Makes change correctly; uses banking facilities correctly
9

30 0 Reading
1 Does not read a simple book or signs
2 Reads a few "survival" words only
3 Reads most "survival" words correctly
4 Reads sentences in simple stories
5 Reads newspaper (S.F. Chronicle or S.F. Examiner) correctly
9

31 0 Number Concept
1 No number concept at all
2 Understands number concept up to 4
3 Understands number concepts up to 9
4 Understands number concepts beyond 10
9

32 0 Writing
1 Does not write name, address or telephone number
2 Writes (or prints) first name only
3 Writes (or prints) full name but not address or telephone number
4 Writes name, address, telephone number and a few words
5 Writes sentences (as in letter-writing)
9

33 0 Telling Time
1 Does not tell time
2 Tells time to nearest hour
3 Tells time to nearest quarter hour
4 Tells time correctly
9

34 0 Use of Social Case Work Services in relation to upsetting experiences
1 Denies or rationalizes his role in relation to upsetting experiences and rejects attempts at clarification
2 Generally denies or rationalizes his role in relation to upsetting experience; will consider clarification attempts, but no carry-over to new experiences is manifested
3 With help of social worker will consider clarification attempts in relation to the upsetting experience, and occasionally has some partial carry-over to new experiences.
4 Accepts clarification attempts in relation to upsetting experiences; handles himself better in similar new situations as a carry-over from social case work services
9

35 0 Participation in Group Activities in Social Groups and Lounge
1 Does not talk to others; does not participate in group activities; an isolate; does not attempt to make friends
2 Does not talk to others, but when asked, joins group games; passive participant
3 Talks to other enrollees; does not participate in group activities
4 Talks to other enrollees; participates in group activities only when encouraged to do so
5 Participates spontaneously and eagerly in enrollee group activities; shows some leadership in group activities
9

36 0 Group Identification
1 No group concept; no group identification or awareness; does not relate ideas to others or plan with or for the group
2 Slight awareness of group; occasionally cooperates with team members and occasionally shares ideas in group planning
3 Fair awareness of group; some awareness of his role in group; interested in being a part of the group; does not follow group norms or forego his ideas for those of the group
4 Good group awareness and group identification; plans cooperatively with group as part of team; shares ideas; compromises with group ideas
9

37 0 Interaction within family and with community groups
1 Does not interact with family members; not a member of any organized community group
2 Interacts with family members only; not a member of any organized community group
3 Interacts with family; a marginal member (nominal or inactive membership) in at least one community group
4 Interacts with family; a regular member and passive and/or regular participant in at least one community group
5 A regular member and active participant in at least one community group
9

38 0 Parent attitude towards Enrollee
1 Parents largely reject enrollee or overprotect him; completely unrealistic as to his degree of impairment
2 Parents minimally accept impairment; overprotect and foster overdependence
3 Parents tend to accept impairment, but also tend to overprotect and to foster overdependence
4 Parents fully accept impairment; treat enrollee realistically in terms of his handicaps
9

This report was collated, stapled and bound by enrollees of the Independent Living Rehabilitation Program, San Francisco, Calif.